Preventing Youth Suicide through Gatekeeper Training

A Resource Book for Gatekeepers

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Introduction to Your Gatekeeper Training Resource Book

The Maine Youth Suicide Prevention Program is a program (MYSPP) of the Maine Children's Cabinet. Gatekeeper training is one of many educational programs offered by MYSPP. This handout has been designed to be used as an integral part of an interactive youth suicide prevention gatekeeper training. Much information is in the training and this material supports topics addressed. It is neither a comprehensive book on suicide nor a treatment manual. It is not intended to be a stand-alone suicide prevention effort. It provides basic information about suicide prevention, offers guidelines for crisis intervention, builds support for survivors of suicide, and provides valuable resource information. The latest version is on-line at http://www.maine.gov/suicide/sgatedet.htm.

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For materials and resources on youth suicide prevention, call the Office of Substance Abuse Information and Resource Center -- 1-800-499-0027. http://www.maine.gov/suicide/

Maine's Statewide Crisis Hotline: 1-888-568-1112

Table of Contents

School Guidelines

Survivors & Grief Centers

APPENDICES

ADDITIONAL MATERIALS (back of book)

AGENDA

Maine Youth Suicide Prevention Gatekeeper Training

(Times Frame (8:00-3:30) & Content may vary slightly depending on needs of participants)

Check-in

Pre-Test

- **Welcome & Introductions & Expectations**
- **The Nature of the Problem of Suicide-What the Statistics Tell Us**
- **Myths & Facts / Beliefs & Attitudes**

Break

- **Risk & Protective Factors, Warning Signs & Clues**
- **Responding to Suicidal Behavior**
- **How to Estimate the Risk of Suicide**

Lunch Break

- **Practice Suicide Intervention Skills**
- **Working w/ Parents& Guardians Through a Child's Suicidal Crisis**

Break

- **Managing the Aftermath**
  The Aftermath of Suicidal Behavior & Suicide in Schools
  Suicide "Survivors" and Suicide Bereavement
- **The Importance of Self-Care**
- **Closing Activities**
  Questions and Answers
  Post Test & Process Evaluation
  Certificates, CEUs * and Adjournment

* All participants receive a certificate of attendance acknowledging .7 CEUs. Contact hours are also available from ANA-Maine, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation and Maine Emergency Medical Services has approved 4.5 Category 1 and 3.0 Category 2 CEHs. Most find that this agenda plus the certificate is all that is needed to receive continuing education credits from local school systems or agencies.

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

Facts on Youth Suicide in Maine

Suicidal behavior is both complex and frightening.
The impact of a youth suicide is devastating to family, friends and the whole community.
Everyone can help prevent youth suicide – please get involved and learn more about youth suicide prevention!

Suicide Completion:

- From 1998-2002 there were a total of 852 suicides in Maine. Of these, 115 were young people aged 10-24, an average of 23 youth suicides per year.
- Suicide is the 2nd leading cause of death for youth aged 15-24 accounting for an average of 21 deaths annually.
- Suicide is the 3rd leading cause of death for youth aged 10-14 accounting for an average of 2 deaths annually.
- More male youth die by suicide than females. Of every 5 suicides, 4 are males.
- More young people die by suicide than from homicide.

Suicide Attempts:

- According to national estimates there are 20 suicide attempts for every completed suicide.
- Female suicide attempts are higher than males.
- From 1998-2001, there were a total of 1,068 documented hospitalizations for self-inflicted injuries among children and youth aged 10-24.
- In the 2003 Youth Risk Behavior survey, 17% of Maine high school students reported having seriously considered suicide. Nine percent reported making at least one attempt in the last 12 months, while three percent reported receiving medical attention for an injury, poisoning, or overdose.

Lethal Means:

- Five of 10 youth suicides are by firearm. Unlike other suicide methods, due to the lethality of firearms, most suicide attempts by firearm are fatal.
- From 1998-2002, 55% of males and 29% of females, ages 10-24, used a firearm.
- Research shows that access to, and availability of, firearms is a significant factor in youth suicide.
- The second leading method of youth suicide is hanging, accounting for almost four of 10 suicides.
- Poisoning is the most common method of non-fatal self-inflicted injuries for both males and females.

Resources:

- For immediate help in a crisis, call the **Statewide Toll Free Crisis Line: 1-888-568-1112** to be connected to a crisis worker near you.
- For more information or youth suicide prevention materials, call 1-800-499-0027 or 207-287-8900; TTY: 1-800-215-7604 or 207-287-4475; email the Information Resources Center at osa.ircosa@maine.gov, or visit the Maine Youth Suicide Prevention Program Web Site at www.maine.gov/suicide.
- For Maine data on suicide, contact the Maine Youth Suicide Prevention Program at 1-800-698-3624 – ext. 75356.

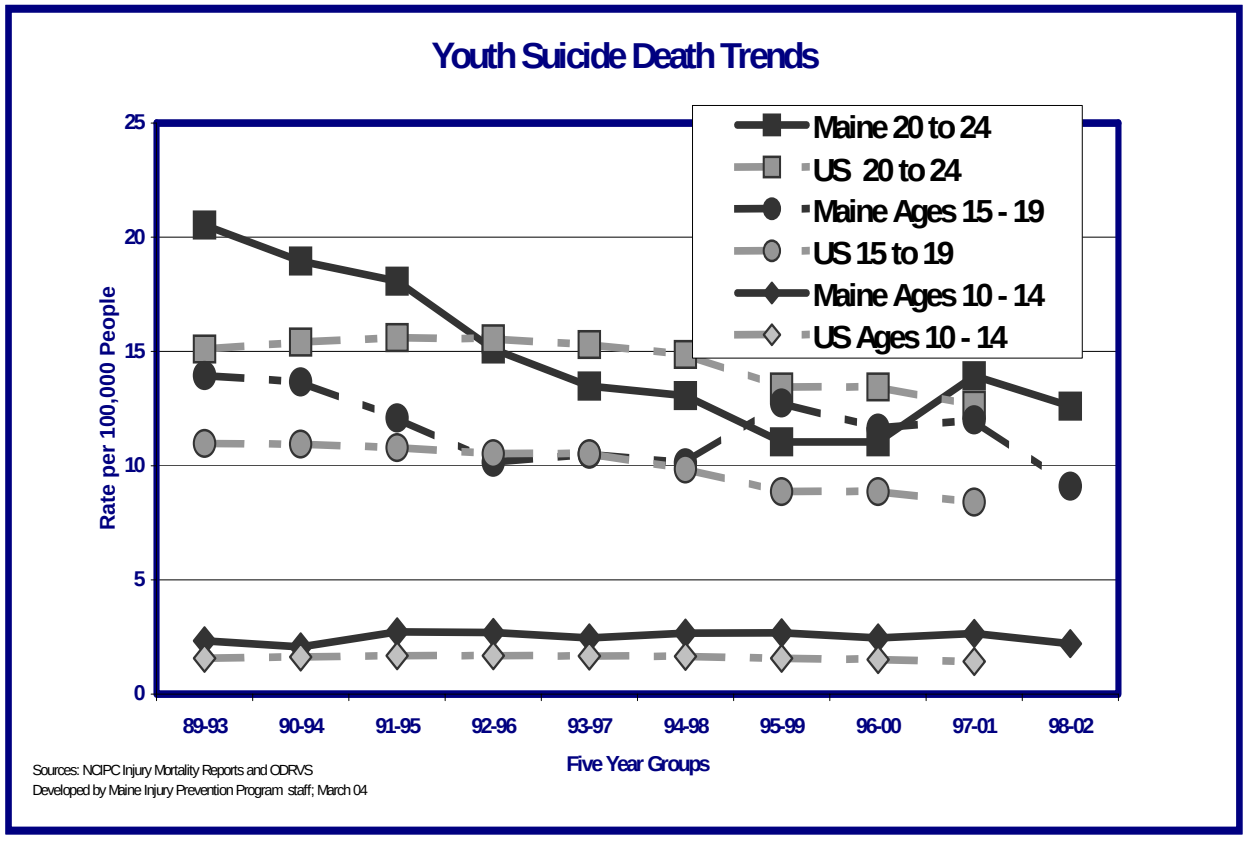
Data from the Maine Office of Data, Research, & Vital Statistics, Maine Hospital Discharge Database, and Maine YRBS. Distributed by the Maine Youth Suicide Prevention Program Updated March 2004

Understanding the Use of Data When Small Numbers are Involved

It is necessary to be very cautious in referring to and using annual mortality (death) rates when the numbers are small. The National Center for Health Statistics qualifies their reports by noting that rates based on fewer than 20 deaths are not considered reliable.

Rates based on small numbers are subject to chance variations. That is, large swings in rates can occur with a difference of one or two deaths.

Due to the small number of Maine youth suicide deaths each year, rates are calculated in five year groupings to give a more accurate picture of trends. Expanding the period of time studied makes the data more reliable.



State of Maine's Youth Suicide Prevention Efforts

The Maine Children's Cabinet has made youth suicide prevention a priority and is committed to addressing the serious, multi-dimensional issue of youth suicide. Several strategies have been integrated into the comprehensive Maine Youth Suicide Prevention Program (MYSPP). The goal of these combined strategies is to reduce the number of attempted and completed youth suicides and to address some of the situations which lead young people to suicide. Statewide efforts are designed to:

- Increase public awareness about how to help prevent youth suicide
- Reach groups of youth known to be generally at high risk with prevention education and intervention information
- Support youths known to be at high risk for self-destructive behaviors with skill building and supportive services to improve individual and/or family functioning
- Encourage and support existing prevention efforts which promote positive youth development
- Develop and/or continue evaluation and surveillance strategies on all program efforts

Statewide activities include:

- Statewide Crisis Hotline (1-888-568-1112)
- Statewide Information and Resource Center (1-800-499-0027)
- Dissemination of print materials and public service announcements
- Youth Suicide Prevention Gatekeeper Training (full-day)
- Suicide Prevention Awareness Sessions (1-2 hour workshops, seminars, conference presentations)
- "Training of Trainers" to present Suicide Prevention Awareness Sessions
- Training for Health Teachers on how to provide School-based Suicide Awareness Education for youth
- Training facilitators to provide skill building groups for youth
- Education on the importance of restricting lethal means to vulnerable youth
- Technical assistance to develop local youth suicide prevention activities
- Data collection, analysis, and dissemination

Rationale for Gatekeeper Training

Unless involved in the mental health field, few people have in-depth knowledge about suicide. Nevertheless, suicide touches most people's lives. It is an emotionally charged topic with a long history clouded by myths and misconceptions. The misinformation perpetuates the personal and social elements related to suicide including denial, shame, stigma, fear, and guilt. Recent years have brought a marked increase in research, knowledge, clinical services, and public awareness about the topic of suicide. Gatekeeper training is designed to provide participants with:

- Increased general knowledge about the nature of suicidal behavior
- Personal confidence and specific skills to recognize, respond appropriately, and refer a suicidal person for help
- Knowledge about how to interact with and assist family and friends in the aftermath of a suicidal event

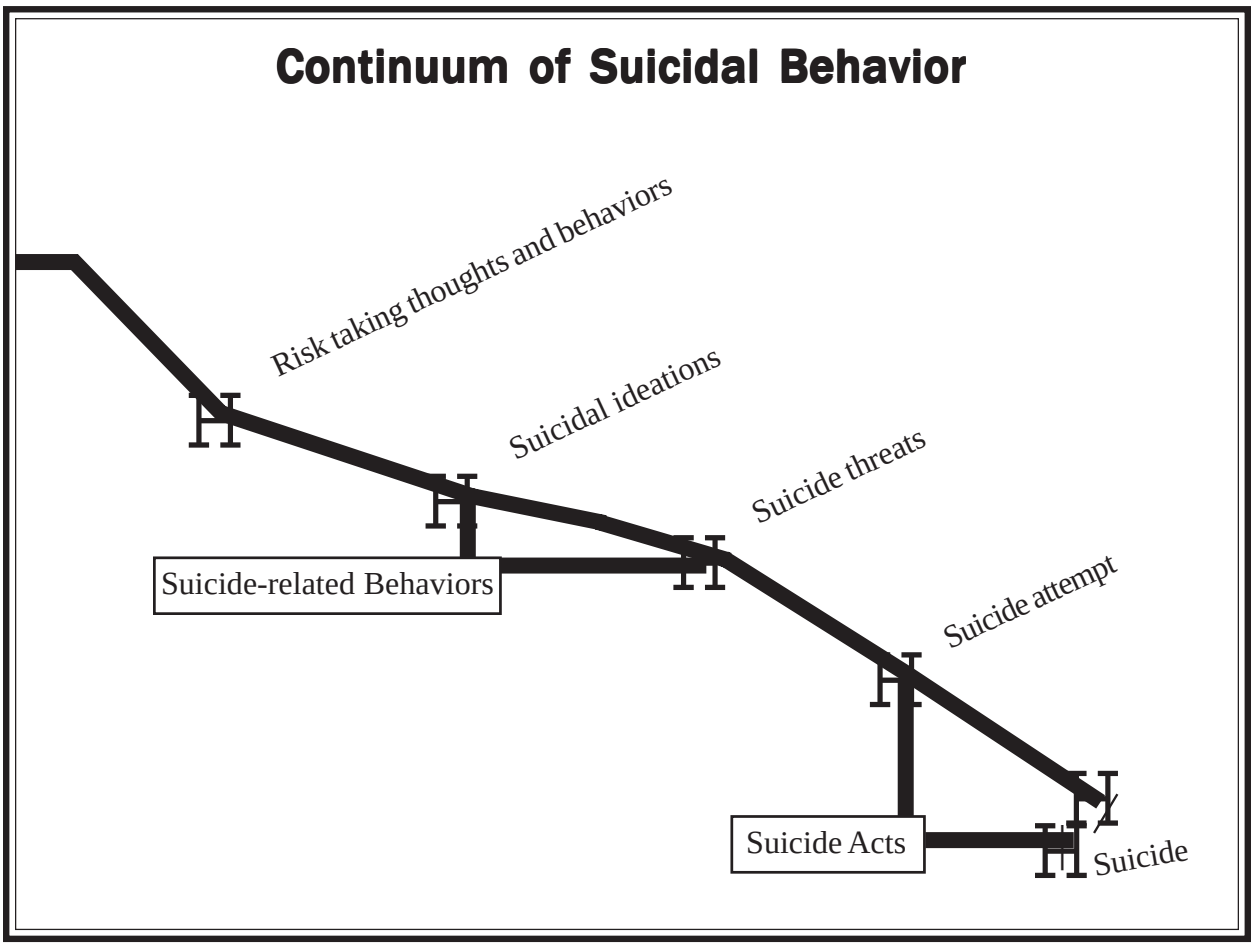
Gatekeeper is a term used to define the role of people who know basic suicide prevention and intervention steps. Gatekeepers are individuals who by the nature of their job, their special interest in people, or in their personal relationships and friendships are in a position to observe high-risk behaviors and take action when necessary. The term "gatekeeping" describes the protective functions the gatekeeper uses in the process of using his or her critical skills in recognizing, responding to, and helping suicidal persons get the help they need.

Gatekeeper Training is the process by which individuals acquire basic suicide prevention and intervention skills. This training focuses on the prevention of youth suicide, but most of the information transfers to suicidal people of any age. The skills and concepts taught in this workshop are easy to learn. While this particular program has been developed for adults, it incorporates some teaching methods appropriate to use with youth by an individual experienced in facilitating youth groups.

Participants are not expected to be an "expert" at the conclusion of the program, nor will they be expected to present themselves as one. The information is not intended in any way to train gatekeepers to replace counseling or mental health services. It is intended to offer hope through positive action in the event of a suicidal crisis.

Language Describing Suicidal Behaviors

The language of suicide is expressed differently by various generations, genders, and ethnicities. In this manual, suicide-related behaviors include any potentially self-injurious behavior for which there is evidence the person intended at some level to kill him- or herself or wished to convey the appearance of intending suicide for some other reason, such as punishing others or receiving attention. It is important to understand that the behaviors appear on a continuum. The behaviors are listed below to reflect increased intensity of suicidal behavior as it moves from risky behavior to a suicide death.



Risk-taking Thoughts and Behaviors
While not necessarily suicide-related, these are ideas and actions for which there is a high likelihood of injury or death, such as engaging in reckless sports, undertaking dangerous activities, consuming large amounts of alcohol, drinking and driving, autoeroticism.

Suicidal Ideation
Any self-reported thoughts or fantasies about engaging in suicide-related behavior. Example: A young person's English class journal entry describes intense feelings of sadness and thoughts of suicide, death, or "ending it all."

Suicidal Threat
Any interpersonal action, verbal or non-verbal, indicating a self-destructive desire, but stopping short of a directly self-harmful act, that a reasonable person would interpret as a suicide-related communication or behavior. Example: A young man threatens to kill himself if his girlfriend breaks up with him.

Suicidal Act or Suicidal Gesture
A potentially self-injurious behavior or act symbolic of suicide, but not a serious threat to life. The act may accidentally result in death, injuries, or no injuries. The individual may report wanting "to see what would happen."

Suicide Attempt
A non-fatal outcome for which there is evidence (either explicit or implicit) that the person believed at some level that the act would cause death. A suicide attempt may or may not cause injuries. Attempted suicides include acts by persons whose determination to die is thwarted because they are discovered and resuscitated effectively, or the chosen method was not lethal. The individual, frequently, reports that the intention was to die. DO NOT refer to a non-fatal suicide attempt as a "failed attempt."

Suicide or "died by suicide" or "died of suicide"
Someone takes his or her own life with conscious intent by lethal means from, for example, use of firearms, injury, poisoning or suffocation. "Committed suicide" implies some level of criminality and "completed suicide" implies earlier attempts when there may have been none. Both terms (committed and completed) perpetuate the stigma associated with suicide. The use of the word "successful" to describe suicide is discouraged, instead say "died by suicide" or "died of suicide." Sensitive use of suicide related language is appreciated.

Suicide Euphoria
Sometimes depressed, despondent, angry, or agitated individuals entertain and then finalize suicidal thoughts that may form into a more defined "suicide pain." After this occurs, the observed behavior in a potentially suicidal person may appear as "suicide euphoria." This seemingly feeling of great happiness or well-being is commonly exaggerated and not necessarily well founded, being based in the notion that "no pain" will exist in the suicidal person's life very soon.

This state of euphoria may fool helpers and gatekeepers who think that a "flight into health" may be taking place. For friends and families of suicide victims, survivors are often confounded with a sense that this was not a suicide because of the cheerfulness of a person expressing this euphoria. When the action of suicide is planned, the vulnerable person may actually be newly calm, and demonstrate short periods of hard to understand happiness.

Sub-intentional Death
Covert or subconscious act of placing self in very vulnerable position, such as victim precipitated homicide, wandering out into oncoming traffic, or jumping out of a moving vehicle.

Suicide Pact
Joint suicides of two or more individuals (close friends, lovers, etc.) which are the result of an agreed upon plan to complete a self-destructive act together, or separately but closely timed. Suicide pacts are a very real part of suicidology and historically have been represented in fiction as well as fact.

Contagion or "Copy-Cat" Suicide
A process by which exposure to suicide or suicidal behavior of one or more persons influences others to attempt or commit suicide. Non-fictional media coverage of suicide has been associated with a statistically significant excess of suicide, which appears to be strongest among adolescents. Several well-publicized "suicide clusters" have occurred. Citizen/community education is vitally important to reduce this risk.

Murder-Suicide
Not to be confused with a suicide pact, this is an event in which one individual murders one or more people and then takes their own life by suicide. The murder victims may be family members, friends, acquaintances, or strangers.

Suicide by Cop
Also referred to as "police assisted suicide" or "victim precipitated homicide," this is another phrase that can mean very different things, depending on how it is used. Sometimes desperate people put themselves in very dangerous positions. Their intent is to die, but rather than kill themselves, they display threatening behaviors to which a policeman will respond and likely kill them. Another scenario, fortunately quite rare, is when a policeman who wants to end his/her life decides to set up colleagues on the job to "take them out." More frequently cops who commit suicide do so in ways to spare their colleagues, and do so with a degree of dignity. All of these behaviors are very difficult for police professionals.

Suicide Survivor(s)
This term is used in two ways. One way is to describe someone who actually attempts and then survives a suicide attempt. The second use describes family members and close friends of a person who has actually died by suicide. If confused, be sure to clarify the use of the term.

Self-Harm
Self-harm is defined as a deliberate and usually repetitive destruction or alteration of one's own body tissue, without suicidal intent. Other terms used to describe this behavior include cutting, self-injury, self-mutilation, self-inflicted violence, and auto-aggression. It appears that self-harm cuts across the boundaries of race, gender, education, sexual preference, and socioeconomic bracket. While difficult to distinguish from a suicide attempt, it is important to understand that the person who engages in this behavior does not intend to die as a result of their actions. They use this behavior to get relief from intense emotions, to calm and soothe themselves. It is possible for self-harm to result in accidental death and it is also possible for suicidal and self-harming behaviors to co-exist in one person.

Facts You Need to Know About Suicide

Misinformation about suicide stands in the way of providing assistance to those in danger. To be an effective gatekeeper, it is important to dispel the "myths" of suicide with some basic facts about suicide and suicidal people. Knowledge about suicide gives us the confidence to recognize suicidal behavior and intervene in constructive, responsible ways.

The facts listed below are not prioritized in any way. They are all important. The numbers are only for ease in reference.

Fact #1 **Talking about suicide or asking someone if they feel suicidal will not put the idea in their head or cause a person to kill themselves.**

Most people thinking about suicide want very much to talk about how they are feeling and are relieved when someone else recognizes their pain. To avoid the subject of suicide can be deadly. Once you ask someone about suicide and they respond "yes," you must be prepared to stay calm, take the time to listen, persuade them to get help, and help them identify resources.

Fact #2 **Few attempted or completed suicides happen without some warning.**

The survivors of a suicide often say that the intention was hidden from them. It is more likely that the intention was not recognized. Research has demonstrated that in over 80% of completed suicides, a warning sign or signs were given.

Fact #3 **There are no special/certain types of people who commit suicide.**

Suicidal behavior cuts across all socioeconomic boundaries. People of all ages, races, faiths, and cultures die by suicide, as do individuals from all walks of life, all income levels. Popular, well-connected people who seem to have everything going for them as well as those who are "down and out" die by suicide. Suicidal youth come from all kinds of families--rich and poor, happy and sad, two-parent and single-parent. Most who die suffer from serious mental illness;

many of whom have not been diagnosed; some have no diagnosable mental illness. We have to pay serious attention to all suicidal talk and behavior.

Fact #4 Suicidal young people can help themselves.

When contemplating suicide, young people develop a distorted perception of their actual life situation and what solutions are appropriate for them to take. However, with support and constructive assistance from caring and informed people around them, young people can gain the life skills necessary to manage their lives. They do not want to die, they want their pain to go away.

Fact #5 Suicide "secrets" and/or "notes" must be shared.

Where the potential for harm, or actual harm, is disclosed then confidentiality cannot be maintained. A sealed note with the request for the note not to be opened is a very strong indicator that something is seriously amiss. A sealed note can be a late sign in the progression towards suicide. Never promise to keep a friend's suicidal thoughts a secret.

Fact #6 Depression, anxiety, mood disorders, substance abuse, and conduct disorders are the most common factors found in suicidal youth. Some, however, have no diagnosable underlying illness.

While mood disorders, conduct disorders, and substance abuse are the most common co-morbid factors, they may or may not be present when a person attempts or dies by suicide. Suicide comes from having more pain than is manageable. In fact, some people who are suicidal appear to be happier than they have been in a long time because they believe they have found a "solution" to all of their problems. Also, extremely depressed people often do not have the energy to kill themselves. Suicidal behavior is very complicated and to a large degree remains a mystery.

Alcohol/drugs and suicide often go hand in hand. Alcohol and other forms of substance abuse cloud judgment and even people who don't normally drink will often do so shortly before killing themselves. Alcohol is a factor in at least a fourth of youth suicides.

Fact #7 Suicide is preventable.

It is simply not true that "once suicidal, always suicidal." Young people can gain the life skills, wisdom, and maturity necessary to manage their lives. Most people who are considering suicide will be suicidal for a relatively short period of time. Most young people are suicidal only once in their lives. Given proper assistance and support, there is a strong possibility that there will not be another suicidal crisis. The more effort that is made to help an adolescent identify stressors and develop problem-solving skills during the post-suicidal crisis period, and the more time that passes, the better the prognosis.

Fact #8 Youth most commonly share their thoughts, problems, and feelings with other youth.

Evidence shows that suicidal youth are far more likely to confide their suicidal thoughts and plans with peers rather than adults. Some adolescents 'ask' for help through non-verbal gestures rather than express their situation verbally to others.

While it is common for young people to be defensive and resist help at first, these behaviors are often barriers imposed to test how much people care and are prepared to help. For most adolescents considering suicide, it is a relief to have someone genuinely care about them and to be able to share the emotional burden of their plight with another person. When questioned some time later, the vast majority express gratitude for the intervention.

Fact #9 Suicide is not painless ... not an "easy way out."

Many suicide methods are very painful. Fictional portrayals of suicide do not usually include the reality of the pain. The pain to the suicide victim, of course, extends to the survivors of the victim, too.

Fact #10 Most suicidal youth are not mentally ill.

Although suicidal adolescents are likely to be extremely unhappy and may be classified as having a mood disorder, such as depression, most do not have a diagnosed mental illness. However, there are small numbers of individuals whose mental state meets psychiatric criteria for mental illness and who need psychiatric help.

Fact #11 People who show marked and sudden improvement after a suicide attempt or depressive period may be in great danger.

The three months following a suicide attempt are critical, especially if the person shows sudden improvement. The apparent lifting of the problems could mean the person has made a firm decision to kill himself and feels better because of this. The initial support and attention may be waning, and life is returning to "normal." The person may be facing the same problems and may have the energy to plan the next attempt. It is a very dangerous time.

Fact # 12 People who talk about suicide may very well attempt or complete suicide.

Talking about suicide makes people uncomfortable. Talking about suicide can be a plea for help and it can be a late sign in the progression towards a suicide attempt. Seven of every ten suicide attempts or completions are preceeded by talk of suicide. All talk of suicide must be taken seriously. Those who are most at risk may also show other signs apart from talking about suicide. It is crucial to remove lethal means from the environment of someone who is talking about suicide.

Fact #13 Suicide is not inherited.

Although suicide can be over-represented in families, there is no "suicide" gene. Members of families share the same emotional environment and the completed suicide of one family member may well raise the awareness of suicide as an option for other family members. Suicide is seen as one model for "coping" in some families and, therefore, its continued expression in certain families should be taken very seriously as a "risk factor."

Fact #14 Suicidal behavior is not just a way to get attention.

All suicide threats and attempts must be treated as though the person has the intent to die. Do not dismiss a suicide threat or attempt as simply being an attention-gaining device. It is likely that the young person has tried to gain attention and, therefore, this attention is needed. The attention that they get may well save their lives.

Fact #15 There is strong evidence that sexual minority youths are more likely than their peers to think about and attempt suicide.

Risk due to discrimination, victimization, or identity confusion because of sexual orientation, as with race and ethnicity, are important factors to consider in youth suicide prevention. Research studies vary greatly in their estimates of gay, lesbian, bi-sexual, transgender, and questioning (GLBTQ) youths who die by suicide. Recent analyses of research indicate that even though adolescents who report same-sex romantic attractions or relationships are at more than two times the risk for suicide attempts, the overwhelming majority report no suicidality at all. Further research needs to be done on the risk factors as well as the unique strengths that characterize the lives of sexual minority adolescents.

Fact #16 Any concerned, caring friend can be a "gatekeeper" and may very well make the difference between life and death.

All people who interact with suicidal adolescents can help them by way of providing emotional support, encouragement, information, and resources. Psychotherapeutic interventions also rely heavily on family and friends providing a network of support.

Fact #17 Not every death is preventable.

No matter how well intentioned, alert, and diligent people's efforts may be, it is impossible to prevent all suicides. Human nature is difficult to predict, and suicidal behavior is the most complicated of hunman behavior. It is important to realize that we will not be able to save everyone. It is equally important to be sensitive to the fact that some people make very impulsive decisions, leaving no time for intervention, and others are very clever at hiding their intentions.

Youth Suicidal Thoughts and Feelings: Understanding Risk & Protective Factors Recognizing Warning Signs and Clues

What We Know

- There is no typical suicide victim.
- There are no absolute reasons for suicide.
- There are no all-inclusive predictive lists of warning signs.
- Suicide is always multi-dimensional.
- Preventing suicide must involve many approaches.
- Most suicidal people are ambivalent about dying.
- Suicidal individuals want to end their pain.

And

- If you reduce the risk factors, you reduce the risk of suicide.
- If you enhance the protective factors, you reduce the risk of suicide.

In A Suicidal Adolescent's Mind:

- Levels of distress /torment/anxiety are seen as overwhelming
- Coping abilities are inadequate
- Suicide is seen as one possible way to end the turmoil
- While ambivalent about dying, may be impulsive by nature
- The need to communicate pain is desperate
- Unable to think about irreversibility of suicide or the consequences/impact of the death on friends and family
- They believe that their thinking is rational

Suicidal thinking in people of any age may include some of the qualities listed above. It is important for Gatekeepers to be aware of these perspectives and not be surprised by them. Counselors and crisis workers are trained to help a person work through these beliefs and find alternatives to suicide. Often asking questions that get at some of ese underlying beliefs allows a suicidal person to let off steam and take steps toward accepting help.

A Word About Very Young Children

Suicide is a rare event in children under ten years old, but they are fully capable of understanding the concept and completing the act. Suicides occurring among very young children are often masked as "accidents," such as the child riding a tricycle or bicycle out in traffic or accidentally "hanging." Generally speaking, when a very young child exhibits suicidal behavior, it is related to external stressors, such as rejection, loss, family deterioration, neglect, and abuse. As the child ages, there is a switch to more internally related stressors such as guilt, aggression, low self-esteem, sense of failure, rage, or hopelessness. See "Additional Materials" section for more on young children.

Signs of Suicide Come in Several Forms

To recognize a suicide crisis you must have knowledge of the potential risk factors, the warning signs, and other clues. Suicide literature provides several different lists of warning signs and clues, risk and protective factors. The average gatekeeper cannot be expected to memorize these lists. However, it is important to be able to recognize the signs of a potential suicidal crisis and understand how quickly a young person can develop suicidal thoughts and feelings.

Given that adolescence is a time of great change and mood swings, viewing a young person who may be at risk for suicide from many perspectives is important. Avoid giving any one sign too much significance. Look for the number of signs, the pattern (several related signs), the duration (two weeks or more of a given pattern), and the intensity of a particular crisis event. Pay special attention to any signal that suggests despair, isolation, depression, distress, and hopelessness. Take the perspective of the person who may be suicidal, and pay attention to your "gut" feelings. It is the combination of feelings and events that may be lethal.

If the thought that someone might be suicidal has crossed your mind, chances are high that it has already crossed their mind.

Risk Factors and Warning Signs

Risk factors are stressful events, situations, and/or conditions that may increase one's likelihood of attempting or dying by suicide. A risk factor is a characteristic that presents itself in statistically significant numbers in a large sample of individuals who have died by suicide. Risk factors do not predict imminent danger of suicide for a particular person. They serve as an indication that an individual *may be* at higher risk. Knowledge of risk factors may suggest a line of questioning and remind us to routinely consider the risk of suicide in our work with individuals. Not all risk factors carry equal weight. Some are more critical than others. For example, multiple previous attempts raise the risk more than a single previous attempt. Other critical factors include having a detailed suicide plan. That is to say, the more resolved and less fearful of suicide a person is, the greater the risk.

Risk Predictors are characteristics of a specific individual that indicate the likelihood of imminent suicide for that person. There is no research to date that shows that a particular set of risk factors can accurately predict the likelihood of imminent danger of suicide for a specific individual. The nature of suicide includes situational, psychological, and biological factors. There is no "typical" suicidal person because each one has varying degrees of external stressors, internal conflict, and neurobiological dysfunction contributing to their suicidal ideation. Suicidal behavior is the most complicated of human behaviors.

Warning signs are changes in a person's behaviors, feelings, and beliefs about oneself for a period of two weeks or longer which are considered to be maladaptive or out-of-character for the individual. Remember to notice or try to discover the pattern, the duration, the intensity, the possible presence of a crisis event, and how the behavior compares to what would be considered normal for this individual. Please note that the warning signs for suicide are very similar to the signs of depression.

It may be helpful to think of the path to attempted or completed suicide as a journey. It is a journey that begins with an idea and ends with an act. Anyone thinking about suicide has to come up with a plan of how, when, and where they will end their life. Young people sometimes behave impulsively and act in just a matter of hours. Some youth suicides follow a conflict or fight, while others follow days, weeks, or months of thinking about self-destruction. The two-week time frame mentioned above represents an average crisis period. It is important to consider the personality of the individual involved and pay attention immediately if you think the situation warrants it.

Other kinds of warning signs and clues: To further complicate the picture, it is important to understand that it is possible for an adolescent to become suicidal without exhibiting any behavior that we ordinarily think of as "depressed" or "suicidal." Some are very clever at "masking" depression by disguising it with impulsive, reckless, and aggressive behavior. They produce a certain excitement by living on the edge. This serves to hide their pain from the world. Parents may react to this kind of behavior with anger and frustration and often find themselves unwilling or unable to help.

Remember, many of us truly believe that people who talk about suicide don't actually do it. The fact is, most people do verbally communicate their intent during the few days prior to their attempt. Perhaps they are checking to see if anybody out there is listening! Sometimes the verbal clues are very direct and sometimes they are coded clues. Examples of what might be said are included in a list on page 26.

When multiple factors overlap in such a way that the pain becomes overwhelming, the idea of suicide as a solution to human suffering may be considered. Youth suicide attempt data collected in Oregon from 1990 to 1993 listed the most commonly reported reasons for the attempt as family discord (59.4%), argument with boyfriend or girlfriend (32.6%), and school related problems (23%.) Other reasons included sexual abuse, physical abuse, or substance abuse.

When family and friends try to understand why a young person attempted or completed suicide, it is common to find that different people held different pieces of the puzzle. It is likely that no one person had enough knowledge about the number of risk factors, was aware of enough warning signs, or had recognized enough clues or observed enough behaviors to be absolutely sure that suicide was a real possibility for a particular individual. That is why we all need to be educated and be willing to talk more openly when something "in our gut" raises a red flag or when we recognize the clues. We need to know what to do, what to say, and how to access, obtain, or arrange for appropriate professional help.

In Summary

It is the combination of risk factors, warning signs, and other kinds of clues that may be lethal. A young person in crisis is unlikely to self-refer to a mental health professional or even pick up a telephone and call a crisis hotline. Intervention is unlikely unless someone recognizes the crisis, responds appropriately, persuades the individual to get help, and helps with the referral process. Preventing suicide is everyone's business.

Protective Factors

Protective Factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for youth suicide as well as other related high-risk behaviors. Just as suicide risks rise from an interaction between familial, genetic, and environmental factors, so do protective factors. They help keep risk factors from becoming overwhelming.

Internal/Personal Protective Factors

- Dominant attitudes, values, and norms prohibiting suicide, including strong beliefs about the meaning and value of life
- Life skills (i.e., decision-making, problem-solving, anger management, conflict management, and social skills)
- Good health, access to health care
- Best friends, supportive significant others
- Religious/spiritual beliefs
- A healthy fear of risky behavior, pain
- Hope for the future
- Sobriety
- Medical compliance
- Good impulse control
- Strong sense of self-worth
- A sense of personal control

External/Environmental Protective Factors

- Strong interpersonal bonds, particularly with family members and other caring adults
- Opportunities to participate in and contribute to school and/or community projects/activities
- A reasonably safe, stable environment
- Difficult access to lethal means
- Responsibilities/duties to others
- Pets

The Profile of a High Risk Youth

Risk factors *most strongly* associated with suicidal behavior:

- One or more prior suicide attempt(s) (the strongest predictor of suicide)
- Depression lasting longer than two weeks; anxiety
- Suicidal ideation and threats of suicide; homicidal ideation
- Exposure to suicide or suicide of a family member or friend
- One or more very stressful events, transitions or losses
- Detailed plan for a suicide attempt (e.g., when, where, how)
- Access to lethal means, especially a firearm

Warning signs associated with *increased suicide potential*:

- School performance problems; academic set backs; learning disability; likelihood of dropping out of school
- Serious family fights and conflict, outrageous, abusive, or unpredictable behavior by parents
- Alcohol or other drug use and abuse
- Isolation, alienation from family, peers (homeless, runaways)
- A conduct disorder -- always pushing to the edge and beyond
- Getting in trouble with the law

Precipitating Factors often *immediately and directly associated* with youth suicide include:

1. **Opportunity** such as access to a gun or other lethal means (especially dangerous for a vulnerable youth), inadequate supervision
2. **An altered or unbearable state of mind** such as hopelessness, shame, despair, rage, intoxication, intense self-criticism or perfectionism
3. **Very stressful life event(s)** recently experienced such as:
    - Interpersonal problems (family, boy/girlfriend); taunting or humiliation from peers
    - Intrapersonal issues (sexuality, morality, etc.)
    - Loss or death of friend/family member, or loss of an important relationship (boyfriend/girlfriend)
    - Loss of self-esteem or negative anticipated outcomes; actual, perceived, or anticipated humiliation, reprimand, parental disappointment or disapproval
    - Disciplinary crisis, loss of freedom (incarceration)
    - Anniversary of someone else's suicide
    - Pregnancy, fear of pregnancy
    - Physical or sexual abuse

Risk Factors

The following lists are representative of information found in suicide literature. While no list is all inclusive, those included below serve to summarize an enormous amount of information.

The Four Most Common Factors in Youth Suicide*

- Depression, mood disorder, anxiety
- Conduct disorder
- Alcohol and other drug use
- Isolation

*These do not cause suicide, but when many factors are present, these will make a difference.

Family Risk Factors

- ☐ Family history of suicide (especially a parent)
- ☐ Changes in family structure through death, divorce, re-marriage, etc.
- ☐ Family involvement in alcoholism
- ☐ Lack of strong bonding/attachment within the family, withdrawal of support
- ☐ Unrealistic parental expectations
- ☐ Violent, destructive parent-child interactions
- ☐ Inconsistent, unpredictable parental behavior
- ☐ Depressed, suicidal parents
- ☐ Physical, emotional, or sexual abuse

Behavioral Risk Factors

- ☐ One or more prior suicide attempt(s)
- ☐ Alcohol/drug abuse
- ☐ Aggression/rage/defiance
- ☐ Running away
- ☐ School failure, truancy
- ☐ Fascination with death, violence, satanism
- ☐ A detailed plan for how, when, where
- ☐ Friends not telling adults about friends who may be suicidal

Environmental Risk Factors

- ☐ Access to lethal means
- ☐ Frequent mobility
- ☐ Religious conflicts
- ☐ Social isolation/alienation or turmoil
- ☐ Exposure to suicide of a peer
- ☐ Anniversary of someone else's suicide
- ☐ Incarceration/loss of freedom
- ☐ High levels of stress; pressure to succeed
- ☐ Over-exposure to violence in mass media

Personal Risk Factors

- ☐ Mental illness/psychiatric condition
- ☐ Depression/anxiety/Bi-polar
- ☐ Poor impulse control
- ☐ Confusion/conflict about sexual identity
- ☐ Loss of significant relationships
- ☐ Compulsive, extreme perfectionism
- ☐ Lack skills to manage decision-making, conflict, anger, problem solving,dirstress,etc.
- ☐ Loss (or perceived loss) of identity, status
- ☐ Feeling powerless, hopeless, helpless
- ☐ Victim of sexual abuse
- ☐ Pregnancy or fear of pregnancy
- ☐ Fear of humiliation

Maine's Statewide Crisis Hotline -- 1-888-568-1112

Suicide Warning Signs and Clues

Early Warning Signs for Suicide/Classic Signs of Depression

- ☐ Difficulties in school
- ☐ Feeling sad, angry
- ☐ Drug/Alcohol abuse
- ☐ Sleep disturbances (too much, too little)
- ☐ Eating disturbances (weight gain or loss)
- ☐ Disinterest in usual activities
- ☐ Restless, agitated, anxious
- ☐ Feeling like a failure/worthless
- ☐ Hopeless, helpless, hapless
- ☐ Pessimistic
- ☐ "Roller Coaster" moodiness-more often & for longer periods than ususal
- ☐ Overly self-critical
- ☐ Persistent physical complaints
- ☐ Difficulty in concentration
- ☐ Preoccupation with death (often through music, poetry, videos)

Late Warning Signs

- ☐ Talk of suicide, death
- ☐ Neglect of appearance, hygiene
- ☐ Dropping out of activities
- ☐ Isolating self from friends, family
- ☐ Feeling life is meaningless, feeling unlovable
- ☐ Hopelessness, helplessness increases
- ☐ Perceived burdensomeness
- ☐ Refuses help, feels beyond help
- ☐ Puts life in order-may make a will
- ☐ Picks a fight, argues
- ☐ Gives away favorite possessions
- ☐ Verbal clues (see below)
- ☐ Sudden improvement in mood, behavior after being down or withdrawn*

**It is important to note that most suicidal people, no matter what their age, suffer from some degree of depression. In young people the depression often goes undiagnosed until a crisis occurs. Depression may leave a person feeling drained, "too tired" to carry out a suicide plan of action. When the depression begins to lift and you notice a sudden improvement, be warned that this could be a very dangerous time. Three months following a period of depression is a critical time of suicidal risk. The person has the energy to act, and may even appear cheerful and at peace with the world.*

Direct Verbal Clues

- I wish I were dead.
- I'm going to end it all.
- I've decided to kill myself.
- I believe in suicide.
- If such and such doesn't happen, I'll kill myself.

Less Direct Verbal Clues

- You will be better off without me.
- I'm so tired of it all.
- What's the point of living?
- Here, take this. I won't be needing it anymore.
- Pretty soon you won't have to worry about me.
- Goodbye. We all have to say goodbye.
- How do you become an organ donor?
- Who cares if I'm dead, anyway?

Maine's Statewide Crisis Hotline -- 1-888-568-1112

(Student Handout taken from Lifelines Suicide Prevention Curriculum)

Warning Signs

Warning signs can be organized around the word **FACT:**

Feelings:

- ❑ Hopelessness- "Things will never get any better." "There's nothing anyone can do." "I'll always feel this way."
- ❑ Fear of losing control, going crazy, harming self or others.
- ❑ Helpless, worthless, "Nobody cares about me." "Everyone would be better off without me."
- ❑ Overwhelming guilt, shame, and self-hatred.
- ❑ Pervasive sadness.
- ❑ Persistent anxiety or anger.

Action or Events:

- ❑ Drug or alcohol abuse.
- ❑ Themes of death or destruction in talk or written materials.
- ❑ Nightmares.
- ❑ Recent loss-through death, divorce, separation, broken relationship, loss of job, money, status, self-esteem.
- ❑ Loss of religious faith.
- ❑ Agitation, restlessness.
- ❑ Aggression, recklessness.

Change:

- ❑ Personality-more withdrawn, tired, apathetic, indecisive or more boisterous, talkative, outgoing.
- ❑ Behavior-can't concentrate on school, work, routine tasks.
- ❑ Sleep pattern-over sleeping or insomnia, sometimes with early waking.
- ❑ Eating habits-loss of appetite and weight or overeating.
- ❑ Loss of interest in friends, hobbies, personal grooming, or other activities previously enjoyed.
- ❑ Sudden improvement after a period of being down or withdrawn.
- ❑ Getting into trouble at school, or with the law.

Threats:

- ❑ Statements, e.g., "How long does it take to bleed to death?"
- ❑ Threats, e.g. " I won't be around much longer."
- ❑ Plans, e.g., putting affairs in order, giving away favorite things, studying drug effects, obtaining a weapon.
- ❑ Gestures or attempts, e.g., overdose, wrist cutting.

Of course, aside from the obvious gestures or threats, none of these signs is a definite indication that the person is going to commit suicide. Many people are depressed and never end their lives. Many experience losses or evidence changes in behavior or demeanor with no indication of suicide. However, if a number of these signs occur, they may be important clues.

Responses to Suicidal Behavior

Suicide is an Impulsive Act That Does Not Occur Spontaneously

It is important to remember that suicide is not usually considered a spontaneous act. That is, people do not suddenly decide to end their lives. They first find themselves in increasingly difficult circumstances, lacking adequate coping skills to deal with their problems. If someone does not intervene, eventually they are unable to cope and may see suicide as an option for solving their problems. Once the idea has been considered, they have to plan the time, place, and means to complete the act. The process may take ten minutes, two weeks, or a lifetime, but typically it takes a matter of days, weeks, or months. While some young people behave very impulsively and move quickly towards suicide, the average crisis period usually lasts about two weeks. Often there is time to intervene. The Gatekeeper's role is to intervene as early as possible.

As you begin your intervention, keep in mind the goals that you need to achieve and what you need to do. Safety is a primary concern, for the youth, for yourself.

The Gatekeeper must be able to:

- **Talk about suicide.** Talk in a direct, clear calm manner.
- **Ask about suicide.** Ask as directly as you can. Gather information.
- **Listen.** Listening shows you care. Listening saves lives.
- **Keep Safe.** Ask about and remove lethal means if possible.
- **Get Help.** Identify and access helpful resources.

Gatekeepers must not:

- **Judge, lecture, get angry**
- **Ignore or minimize the suicidal behavior**
- **Try to solve all the problems**
- **Promise secrecy**
- **Get over-involved or over-react**
- **Make promises that can't be kept**
- **Leave the suicidal person alone**

Initial Response to Suicidal Individuals

This reviews the appropriate initial response to someone who is either openly threatening or talking about suicide, or who is showing warnings signs, or is known to have risk factors, or to have experienced precipitating events. The most basic goal here is to engage the person and to assess the likelihood that they will try to harm or kill themselves. This risk may range from the fact that they are thinking a lot about it and need to talk with someone, or they seem to be resolved to try suicide or are unable to control the impulse to harm or kill themselves and need to be transported to a crisis center or hospital. These encounters all start in one of two ways: *the suicidal person* brings up suicide or *you* bring it up in response to the distress/warning signs that you are seeing, or because a third party has brought the individual to your attention.

A Person Brings Up Suicide via Direct Statements or Threats:

- **Stay calm**: (at least outwardly) look at them directly and speak in a calm but clear and concerned tone.
- **Do not leave the person alone**, even to go to the bathroom. Let them know that you are not going anywhere.
- **Buy time**: encourage the person to talk and let him/her know you are hearing him/her. It almost doesn't matter what you talk about, because the more the two of you talk, the harder it is for them to maintain the energy necessary to take action.
- **Acknowledge** what you are hearing and convey that you are taking it seriously. Acknowledgement always precedes alternatives, directives:
  "I'm hearing that this feels hopeless to you and I'm thinking that there may be a way to deal with this that we haven't thought of yet."
  "I can see that you are very upset and I need for you to put the gun down so we can talk."
- **Listen** to what the person is saying and let him/her know that you are hearing him/her by reflecting back what you are hearing.
  "It sounds like you are having some very rough times and you don't see any way to deal with this."
- **Convey** that you hear that they see suicide as an only option and let them know that you believe that with help other possible options can be discovered.
  "I hear that you are thinking of (planning to) kill (or harm) yourself. Something must have gotten you very upset to reach this point. I'm concerned and I would like to help you find another way of handling this" or "I want to help you get to someone who can help you."

- **Ask for** any pills: **be directive** (ask that weapons should be put out of reach or with someone else).
  "Let me take those pills for now."
- **Note the time** any pills were taken so you can provide this information to the person(s) you may be handing off to.

You Bring Up Suicide in Response to Warning Signs or a Referral

- **Review** your evidence--what is happening, what is the person doing that causes your concern?
  "Tom, I understand (or, other people have noticed) that since you didn't get your promotion, you haven't been going out with your friends, you haven't been eating much, and you've been drinking a lot more."
- **Inquire** about feelings or state what you have seen or heard:
  "It would be normal to be upset about the promotion--it seems as if you have been taking it pretty hard, is that right?"
- If you get denial, **persist**:
  "Well, you really have been down (or acting differently)--again, that's understandable, but I wonder (or I'm concerned about) how bad this has been for you."
- Use the "**sometimes**" approach:
  "Tom, sometimes when people feel as bad as you do they have thoughts of harming or killing themselves."
- **Ask directly**:
  "Have you had thoughts of harming or killing yourself?"
  "Are you thinking about suicide?"
- **Offer help**:
  "I'd like to try to help you come up with ways of handling this without hurting yourself."
- If you get **denial** and do not feel convinced, let them know:
  "Tom, you say you haven't thought about killing yourself, but I'm still concerned."

To Increase Safety:

- Don't leave the person alone or send the person away.
- Don't over-react--don't be shocked by anything s(he) says. You need to show your care, concern, and willingness to listen nonjudgmentally.
- Don't rush--remember, you are trying to establish contact and begin the process of resolving the crisis.
- Don't minimize the person's concerns--e.g., *"This is not worth killing yourself over."* Remember to acknowledge: *"I see this is very upsetting to you and I want to help you."*
- Don't discount or make light of the suicidal threat: e.g., *"You don't really want to kill yourself."*
- Don't argue whether suicide is right or wrong.
- Don't preach or moralize--e.g., *"You have everything to live for."* The issue is the problem or bind the person feels s(he) is in, not life and death per se.
- Don't challenge or get into a power struggle. You will do everything you can to get help right now, but ultimately s(he) has control over his/her decision.
- Don't think the person just needs reassurance. Take immediate steps that show you will be helpful.
- Don't promise to keep the conversation confidential. There is no confidentiality in life-threatening situations.

- **Do remember** that all persons who are at risk for suicide need help. It is always better to over-react (in terms of taking action) than to fail to take action. It is better to have someone angry with you or embarrassed than dead.
- **Do take care of yourself** by asking for a debriefing session. Professionals always do.

Used with permission from John Kalafat, Ph.D.

Three Steps to a Basic Suicide Intervention

1. Show You Care

- Take all talk of suicide seriously.
- Do whatever you can to create privacy.
- Be absolutely attentive, listen very carefully and reflect what you hear.
- Use language appropriate for the age of the person involved.
- Do not worry about doing/saying exactly the "right" thing…your genuine interest is what is most important.

2. Ask About Suicide

- Talking eases stress and tension and often allows the crisis to slow down.
- If you are even remotely wondering if you should ask about suicide, ASK.
- Stay calm, caring and non-judgmental.
- Ask as directly and clearly as possible (sample questions below):
    - *"Are you thinking about killing yourself?"*
    - *"Are you thinking about suicide?"*
    - *"You seem very unhappy, are you wishing you were dead?"*
    - *"Has the idea of suicide been on your mind?"*
    - *"Tell me what you have been thinking…"(and depending upon your comfort level and experience, ask how, when, where, who else knows about this…)*
- Remember, if the answer to your question about suicide is "yes," you do not have to solve all of his/her problems, but you must get help.

3. Get Help

- Reassure the person that help is available and that you will help them get help.
- Follow the protocols at your school or agency for getting help, calling parents or guardians, crisis providers or other appropriate resources.
- Encourage the suicidal person to identify helpful resources.
- Make arrangements for the helper(s) to come to you OR take the person directly to the source of help.
- Set up or provide referral resources as necessary for parents or guardians.
- Outline a plan for safety (see p. 34) and plan specifically for follow-up.
- Stay with the person until the immediate crisis has passed.

The Three Basic Steps to a Suicide Intervention*

1. **Show You Care – Listen Carefully – Be Genuine**
   "I'm concerned about you…about how you are feeling."

2. **Ask About Suicide – Be Direct, but Non-Confrontational**
   "Are you thinking about suicide?"

3. **Get Help – Do Not Leave the Person Alone**
   "You are not alone. I will help you."

* This three-step suicide intervention model is used with the permission of the Youth Suicide Prevention Program, Seattle, Washington. The Maine Youth Suicide Prevention Program is most appreciative.

Participant Notes:

Safety Plans/Contracts for Safety

A contract, a promise, a "plan for safety" (verbal or written) all describe an agreement between yourself and a youth whom you feel is at risk for suicide, but not acutely suicidal. It is meant for low risk situations. While it is highly unlikely to cause any harm, it provides absolutely no guarantees. If the "helper" or clinician has the sense that creating a safety plan is the only intervention they need to do, it may even increase the risk. The young person may make a suicidal attempt whether or not they form such an alliance. However, planning for safety does allow you to:

- gain some sense of their impulse control and the seriousness of their suicidal ideation
- demonstrate that you care about them and are willing to work with them, listen to them, and help identify resources
- work with the youth to think through what to do and who to turn to when they feel suicidal
- clarify any steps taken to get help from others

Different Points of View:

Some people believe that contracting or planning for safety is a key step in suicide prevention. Others feel it has little, if any value. Some people believe that you need to have an already established trusting relationship in order for a contract or plan to mean anything, while others have found that it works well as a simple way of expressing care and concern even in the absence of a long term trusted relationship. You will have to make your own judgment about taking this step. You must consider the policies and procedures outlined by your school or agency. It is always a good idea to document verbal and written conversations about the plan for safety, whether the youth agrees to it or not. Document and pass on to your supervisor all signed and verbal agreements and a summary of your interaction with the youth. If there are any questions at a later date, your memory is not to be trusted. Remember, there are no guarantees.

Factors That Increase the Likelihood That a Safety Plan or Contract will be Rendered Useless:

- Anything you plan with someone you don't know well.
- Any time the plan or contact is the only intervention.
- Any plan or contract that is limited to directives/promises to refrain from a particular behavior.
- Any time a person's ability to care for self depends upon unreliable others.
- May be of limited value with children especially if they are immature, impulsive, agitated, or anxious.
- Any time the person is using and/or abusing substances.

Factors That Contribute to a Potentially Useful Safety Plan or Contract:

- An existing friendship or trusting relationship with the individual.
- A prior history of a working relationship in which you have been helpful and directive.
- Specific, doable directives toward positive action that the individual has helped to construct and is capable of doing. Structure reduces anxiety.
- Confirmation that others involved in the plan are, in fact, available, informed of the situation, and willing to help.
- Follow-through and follow-up as promised!
- A promise or "agreement" not to die may appeal to the person's code of honor.

Supporting Parents Through Their Child's Suicidal Crisis

Family Support is Critical

When an adolescent experiences a suicidal crisis, the whole family is in crisis. If at all possible, it is important to reach out to the family for two very important reasons:

First, the family may very well be left without professional support or guidance in what is often a state of acute personal shock and distress. Many people do not seek help—they don't know where to turn.

Second, informed parents are probably the most valuable prevention resource available to the suicidal adolescent.

Remember, a prior attempt is the strongest predictor of suicide. The goal of extending support to the parents is to help get them to a place where they can intervene appropriately to prevent this young person from attempting suicide again. Education and information are vitally important to family members and close friends who find themselves in a position to observe the at-risk individual.

Common Parental Reactions to Hearing that their Child is Suicidal

- Acute personal shock and distress
- Totally paralyzed by anxiety
- Very confused, puzzled, or in denial
- Embarrassed
- Blamed, stigmatized
- Angry, belligerent, threatening

Concerns of the Helper/Professional

- Safety of the youth
- Professional responsibilities
- Gaining cooperation from parent(s)

Concerns of the Parent

- Maintain some equilibrium
- What to do; Where to turn for help
- The safety of the youth

Parents May Need Support to:

- Overcome their emotional reactions
- Accept the seriousness of the situation
- Recognize their key role in helping their child
- Recognize the importance of finding (professional) help
- Understand the importance of removing firearms from their environment
- Identify personal coping mechanisms and support systems
- Understand their limits
- Establish some hope

How Gatekeepers Can be Helpful

- "Just be there" (through the immediate crisis)
- Reflective listening - acknowledge the impact, the fear, the anger ...
- Avoid judging, blaming
- Provide information and referrals
- Emphasize safety; strongly recommend removing lethal means from the home and provide information on how to do that
- Support any and all acceptance of responsibility and efforts to help
- Model limit setting and self care

Things you can ask—or say—once the immediate crisis has passed:

- How can I help?
- How are you coping?
- Who can you talk to? How are you in touch with these people? Would it help if I called them for you? (sometimes just picking up the phone is more than they can do for themselves)
- "I can appreciate how this has turned your world upside down. It is great that you have been willing to get help. None of us can do this alone."
- "How have we (professionals) been helpful? What has not been helpful? What could we do better?

Suggestions That May Help Enlist Parental Cooperation (offered by gatekeepers who have worked with parents of suicidal youth)

1. Invite the parents' perspective. State what you have *seen* (rather than the results of your assessment) and ask how that fits with what they have noticed going on.

2. Advise them to remove lethal means from the home while the child is vulnerable -- just as you would advise taking car keys from a youth who had been drinking. Include the fact that you had this conversation in your notes. Consider having them sign a form acknowledging the conversation.

3. Comment on how scary this behavior is and how it complicates the life of everyone who cares about this young person.

4. Acknowledge their emotional state, including anger, if present.

5. Ask, "What it would take to help you understand the seriousness of the situation?" (Develop a form for them to sign that outlines that you have discussed suicide as an issue for their child and steps to be taken.)

6. Acknowledge that none of us can do this alone - appreciate their presence.

7. Listen for myths of suicide that may be blocking the parent from taking action.

8. Explore reluctance to accept a mental health referral, address those issues, explain what to expect.

9. Align yourself with the parent if possible ... explore how and where these kids get this idea ... without in any way minimizing the behavior.

10. Other:

See "Additional Materials" Section for Frequently Asked Questions to share with parents.

Five Minutes Can Save a Life
A Three Step Intervention to Use With Parents of Suicidal Adolescents

This is a very important Gatekeeping intervention. It is as sensible as taking the car keys away from an intoxicated individual. It may very well mean the difference between life and death for an adolescent.

1. **Inform the parents that their adolescent is at risk for suicide and why you think so.** For example, if you are working with an adolescent who is known to have made one attempt, it is important to inform the parent or caretaker that "Adolescents who have made a suicide attempt are at risk for another attempt. One attempt is a very strong risk factor for another."

2. **Tell parents or caretakers that they can reduce the risk of suicide by removing firearms from the house.** Research shows that the risk of suicide doubles if a firearm is in the house, even if the firearm is locked up. It is extremely important to help parents or caretakers understand the importance of removing access to firearms and other lethal means. Two-thirds of Maine's youth suicides are committed with a firearm. This is important information for all parents, even if they do not own a firearm. Access to lethal means may be readily available at the home of other family members, friends, or neighbors. Every effort must be made to remove all access to lethal means.

3. **Educate parents about different ways to dispose of, or at the very least, limit access to a firearm.** Officers from local police departments, sheriff's offices, or state police barracks are willing to discuss removing, storing, or disposing of firearms.

For More Information:

- If you are concerned about a loved one or friend who may be in crisis, call the Statewide Crisis Hotline at 1-888-568-1112.
- To learn more about Maine's Youth Suicide Prevention Program, call the Childhood Injury Prevention & Control Program at 1-800-698-3624 or 287-5356.
- To receive materials on youth suicide prevention call the Statewide Information and Resource Center at 1-800-499-0027.

Building School Readiness Steps to Prevent Youth Suicide

One in eleven Maine high school students report actually attempting suicide within the past twelve months on the Youth Risk Behavior Survey. The school role in preventing youth suicide is a limited, but crucial one. Youth suicide prevention is an important part of creating a safe climate within the school community.

A guiding principle of the Maine Youth Suicide Prevention Program (MYSPP) is *Do No Harm.* We strongly believe that it is extremely important to have prevention and crisis intervention systems in place to identify and help young people at risk of suicide before any direct suicide education is done with students!

Based on current research, the Maine Youth Suicide Prevention Program recommends the following components to aid school personnel in identifying and appropriately assisting students at risk for suicide.

1. **Administrative Procedures in Place** to guide school personnel in responding effectively to suicidal behavior in troubled students, in those who threaten or attempt suicide, and in others potentially at risk in the aftermath of a death by suicide. Procedures clarify for school personnel their role in suicide prevention and crisis intervention and lessen the burden on individual school employees.

2. **Agreements with Local Crisis Service Providers** that outline prevention and crisis intervention services to be provided to the school system such as:
    - Conducting student risk assessments.
    - Helping with crisis management.
    - Debriefing school staff in the aftermath of a crisis.

3. **Educational Programs to Increase Knowledge about Suicide Prevention:**

    - **Youth Suicide Prevention "Gatekeeper" Training** for designated school personnel who are available to each school building to intervene and refer a potentially suicidal youth.

- **Basic Suicide Prevention Information Awareness Sessions** for ALL school personnel including administrators, teachers, custodians, cafeteria workers, coaches, bus drivers, secretaries, aids, educational technicians, and other support staff.

- **Suicide Prevention Information and Resource Materials for Parents.**(See sample "Information Booklet" Available free of charge from Information & Resource Center 1-800-499-0027.)

- **Suicide Prevention Education for Students,** within a comprehensive school health education program. *Student education should only be done after procedures are established and school personnel are educated.*

4. A Range of School and Community-based Support Services for At-risk Students.

MYSPP Resources Include:

- Suicide Prevention, Intervention & Postvention Guidelines
- A variety of training programs for school staff and community members
- Technical Assistance

Is Your School Prepared to Manage Suicidal Behavior?

While not an exhaustive list, the following questions will help guide you in deciding how to develop school protocols to address suicide prevention, intervention and postvention.

Administrative Questions:

Prevention:

1. Does your school have an up-to-date crisis intervention plan?
2. Does the crisis plan include specific guidelines for handling suicidal behavior?
3. Are crisis team members identified? Are individuals from both the school and the community involved on the crisis team?
4. Does the crisis plan have solid administrative support?
5. Is the school administration clear about the legal rights and obligations of administrators, faculty and staff in assisting with a suicidal student?
6. Does anyone track how many suicides, suicide attempts and/or referrals for suicidal behavior there are each academic year?
7. What is your policy for maintaining confidentiality of sensitive student information?
8. Do you have a formal "Memorandum of Agreement" (MOA) with your local/regional crisis service providers outlining the services to be provided to the school system such as student risk assessments, crisis management, and/or debriefing school staff in the aftermath of a crisis? Does the agreement include debriefing parents and community members in the event of a suicide?
9. Does this "MOA" include guidelines for how the school receives feedback on the outcome of the referrals they make?
10. Do you know what you can expect for help from the local law enforcement agency in the event of a crisis in school buildings or on school grounds?
11. What kind of education and training have school administrators, faculty and staff had in suicide prevention?

Intervention

12. Are key people identified within each building in your school system as contacts to help when suicidal behavior occurs? Have back-ups been designated in that person's absence?

13. Does the crisis plan have written protocols on how to manage suicidal behavior? I.e. Attempt on campus? Attempt off campus?

14. When, and who contacts parent/guardian when suicide risk is suspected? What is done if the parent/guardian is unreachable, uncooperative? Do you know what steps you will take to encourage parents to get help for their children and what steps to take if they refuse?

15. Do you have protocols on how to help a student re-enter school after an absence or hospitalization for mental illness including suicidal behavior?

Postvention

16. Have you established protocols for how you will work with the media in the event of a suicide?

17. In the event of a suicide, do you have established methods for identifying close friends/other vulnerable students and a plan to support them?

18. Does your school have protocols in place that explicitly detail what to do following a suicidal crisis to avoid copycat behaviors?

19. Does your school have clear parameters around the role of the school following any student/staff death (for any reason) that take into consideration the fact that following a suicide, whole-school memorials and permanent memorials are NOT recommended?

20. How are the protocols disseminated and to whom?

21. Have you incorporated an effective student suicide prevention education curriculum into your Comprehensive Health Education Program? Does the curriculum include a focus on building help-seeking skills? *(Student curriculum in suicide prevention is not recommended until school protocols have been established, MOAs are in place, staff education has occurred and key staff identified as those who can help with suicidal behavior.)*

22. How does your system support/address the needs of students who are exhibiting high-risk behaviors such as substance abuse, etc.?

Staff Related Questions:

1. What measures have been taken to educate key staff about suicide?
2. Have ALL staff been provided with in-service education on suicide prevention and your school's related protocols?
3. Have individuals (and back-ups) in your building been identified as contacts for when suicidal behavior occurs?
4. Does everyone in the building know who these contacts are?
5. Is it clear to school personnel what to do if they happen to be a first responder (anyone who comes upon or hears about a suicide event?)?
6. What guidelines address issues of confidentiality around suicidal behavior?
7. Is the staff taught to pay attention to student work/ messages that focus on death or suicide? (i.e. artwork, doodling, homework, term papers, journal entries, notes passed between students, notes crumpled up and "found," graffiti)
8. Do teachers get any feedback on students whom they refer for an evaluation of suicidal risk?
9. Are there protocols on how to help a student re-enter school after an absence or hospitalization?
10. Do school personnel understand that it is not their responsibility to assess how serious the situation is…that ALL suicidal behavior is to be taken seriously and reported according to the school protocols?
11. Does everyone know what to do if there is any reason to suspect a weapon is present/readily available?
12. How are staff briefed …and de-briefed in the event of a crisis?

Parent Related Questions:

1. Does your school provide opportunities for parents to learn about suicide prevention?
2. Is it possible for parents to attend suicide prevention educational sessions provided by your school?
3. Are there any efforts to actively communicate with parents, informing them about risk factors, warning signs and the importance of restricting lethal means?
4. Have parents been told what the school is doing to prevent and address the issue of suicide, what will be done if your son or daughter is thought to be at risk for suicide as well as what is expected of you?
5. Are parents provided with a list of community resources or agencies that they may contact if they are concerned about their son or daughter being suicidal?

Student Related Questions:

1. Does your school educate all students about suicide and how to help a troubled friend?
2. Would students in your school know whom to go to in the school if they were worried about a suicidal friend?
3. Are behavioral health resources readily available to youth?

For more information on Youth Suicide Prevention, Intervention and Postvention Guidelines, visit the Maine Youth Suicide Prevention Program Website at:
http://www.maine.gov/suicide/sinfores.htm

Guidelines for Schools

In response to many requests from Maine schools for help in managing suicidal behavior and/or death by suicide, the Maine Youth Suicide Prevention Program (MYSPP) developed **Youth Suicide Prevention, Intervention and Postvention Guidelines, A Resource for School Personnel**. This was a collaborative effort with the Maine School Management Association, the Maine Principals' Association, the Departments of Education and Human Services, the Maine Attorney General's Office and many others. Every school in Maine received a copy in the Spring of 2002.

Recognizing that each school community is unique, these guidelines are offered as an aid in discussion and planning for crisis response. The document recognizes and builds on the skills and resources inherent in school systems. Schools are exceptionally resilient and resourceful organizations whose staff members may be called upon to deal with a crisis on any given day. The likelihood of students, faculty or staff encountering a suicidal student is real, even at the elementary school level. Few events are more painful or potentially disruptive than the suicide of a student. Schools can be a source of support and stability for students and community members when such a crisis occurs.

The Guidelines are available on the MYSPP website: http://www.maine.gov/suicide/sinfores.htm.

Only the Table of Contents and Appendix D from the Guidelines are included in this section of this book.

Maine Youth Suicide Prevention, Intervention, and Postvention Guidelines

Table of Contents **Page**

Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior

This information is found in the Youth Suicide Prevention, Intervention & Postvention Guidelines published by the Maine Youth Suicide Prevention Program and mailed to all schools in May 2002.

Students who have made a suicide attempt are at increased risk to attempt to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to render assistance. Although necessary for effective assistance, it is often difficult to get information on the student's condition. If possible, obtain a signed release from parents/guardians to communicate with the student's therapist. Meeting with parents about their child prior to his/her return to school is integral to making decisions concerning needed support and the student's schedule.

Some suggestions to ease a student's return to school are as follows:

1. Prior to the student's return, a meeting between a) a designated liaison person (such as school nurse, guidance counselor, social worker, administrator or other adult designee trusted by the student), b) parents/guardian and c) the student should be scheduled to discuss possible arrangements for services and to create an individualized re-entry plan.

2. The designated liaison person is responsible to:
    a. Review and file written documents as part of a confidential health record.
    b. Serve as case manager for the student. Understand what precipitated the suicide attempt and be alert to what might precipitate another attempt. Be familiar with the practical aspects of the case, i.e. medications, full vs. partial study load recommendations.

c. Help the student through re-admission procedures as necessary, monitor the re-entry and serve as a contact for staff members who need to be alert to re-occurring warning signs.
d. Serve as a link with the parent/guardian, and with the written permission of the parent/guardian, serve as the liaison with any external agency staff providing support to the student.

3. Classroom teachers need to know whether this student is on a full or partial study load and be updated on progress. They do not need the clinical information or detailed student history. *Only the liaison needs to know what precipitated the suicide attempt so that s/he can be sensitive to what might precipitate another attempt.*

4. Discussion of case among school personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be strictly on a "need to know" basis. That is, information directly related to what staff has to know in order to work with a student.

5. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality, and such discussion would serve no useful purpose to the student or his/her peers.

6. It is appropriate for school personnel to recommend to students that they discuss their concerns or reactions with an appropriate administrator or other designated school personnel. The focus should not be on the suicidal individual, but on building help seeking skills and resources for others who might be depressed or suicidal.

Other Issues and Options: *Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some of the school staff, the family, the mental health professional and the student will express concerns. Some of the more common issues are listed below:*

1. **Issue: Social and Peer Relations**

   Options:

   - ❑ Speak to student about how he/she wants to share information with peers and the type of support that will be most helpful.

- ❑ Schedule a meeting with friends prior to re-entry to discuss their feelings regarding their friend, how to relate and when to be concerned.
- ❑ Arrange for friends to visit the hospital or home with permission from the parent, student and therapist.
- ❑ Place the student in a support group.
- ❑ Refer the student to a peer helpers program or buddy system.
- ❑ Arrange for a transfer if indicated.
- ❑ Be sensitive to the need for confidentiality and how to restrict gossip.

2. **Issue: Transition from the hospital setting**

Options:

- ❑ Visit the student in the hospital or home to begin the re-entry process.
- ❑ Obtain a signed release from the parents so the school can communicate with the therapist.
- ❑ Request permission to attend the discharge conference.
- ❑ Invite the therapist to attend the school re-entry planning meeting.
- ❑ Consider allowing the student to attend school on a part time basis before discharge from the hospital.

3. Issue: Academic problems

Options:

- ❑ Provide tutoring from peers or teachers.
- ❑ Modify the schedule and adjust the courses to relieve stress.
- ❑ Allow make-up work to be adjusted and extended without penalty.
- ❑ Monitor student's progress.

4. **Issue: Family concerns (denial, guilt, lack of support, social embarrassment and anxiety, etc.)**

Options:

- ❑ Schedule a family conference with the school psychologist or home school coordinator to address their concerns.
- ❑ Include the parents in suicide awareness and parenting workshops.
- ❑ Invite parents to attend the re-entry planning meeting.
- ❑ Refer the family to an outside community agency for counseling services.
- ❑ Arrange for continuing support by the school's primary caregiver.

5. Issue: Behavior and attendance problems

Options:

- ❑ Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
- ❑ Consult with discipline administrator.
- ❑ Request daily attendance report from attendance office.
- ❑ Make home visits or regularly schedule parent conferences to review attendance and discipline record.
- ❑ Provide counseling for student.
- ❑ Place the student on a sign in/out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

6. Issue: Medication

Options:

- ❑ Alert the nurse to obtain information regarding the prescribed medication and possible side effects.
- ❑ Notify teachers if significant side affects are anticipated.
- ❑ Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

7. Issue: On-going support

Options:

- ❑ Assign a mentor to meet regularly at established times.
- ❑ Contact the therapist and parents frequently. If leaving a message, state your schedule/availability so it will be easier to connect.
- ❑ Ask the student to check in with the counselor daily/weekly.
- ❑ Make a no-suicide contract/safety plan with primary caregiver. Re-assess the suicide risk if necessary.
- ❑ Utilize established support systems, Student Assistance Teams, support groups, friends, clubs and organizations.
- ❑ Schedule follow-up sessions with the school psychologist or home school coordinator.
- ❑ Assure that the family follows through with community referrals and has a resource available when school is not in session.

For more information call (822-0126 or 1 800-492-0846) and ask for Susan Lieberman. The "Psychiatric Facility and School Transition Initiative" is sponsored by the Regional Children Cabinets.

In the Aftermath of a Student Suicide...

☐ **Keep the School Open.** The school community serves as the center of operations in times of crisis. It is a very important source of support and information.

☐ **Consult Your Crisis Plan.** Crisis Team planning and preparation allow the community to function and move forward, even when in a state of shock and consumed by sadness. Systems are in place and ready to serve students, staff, parents, and others. Each crisis presents some unique qualities and the plan can be adjusted as necessary.

☐ **Plan for Media Involvement.** Establish media control. Assign one school authority/spokesperson to interact with the media. A fine line needs to be walked to ensure honest reporting of the student's involvement in the school. Never speculate as to why the student committed suicide. Focus on the positive steps of the school's postvention plan to help students through the crisis. Also emphasize resources for help. (See Appendix B for "Reporting on Suicides.")

☐ **Contact the Family.** The principal, along with a selected member from the crisis team, should visit the victim's family at home. In addition to the expressions of sympathy and support, explain the school's plan for helping the grieving survivors. The family may assist in identifying friends and siblings in schools who may need assistance. Advice can be given with regard to contacts by the media. Contact and support from the school are usually greatly appreciated by the family.

☐ **Return Personal Belongings.** This can be a time to offer assistance in retrieving their child's personal belongings from lockers and other locations, such as desks. Parents may wish to do this in privacy or have someone else do it for them.

☐ **Provide Fact Sheets.** The death and the fact that it was a suicide should be acknowledged. Do not give details of the method. Keep parents informed on warning signs and resources for help for themselves, siblings, and friends as well as activities, services, and support available at school. Consult with local law enforcement as appropriate. A faculty fact sheet should include detailed information on schedules, debriefing meetings, crisis center activities.

☐ **Communicating the News.** Do not hold large school assemblies and public address announcements about any suicide. There is evidence to the effect that these actions tend to memorialize and romanticize suicide, thus extending the problem. It is better to address the situation on a smaller scale, for example, in homeroom discussions with trained personnel, or in advisor/advisee groups which allow the opportunity for greater small group or individual contacts.

☐ **Determine Intervention Groups.** Identify those who might need assistance, i.e., the deceased student's classmates, friends, siblings (and their schools), teachers/other school staff, other parents, at-risk youth. Provide mental health counseling as appropriate. Provide relief for impacted staff. Provide daily staff and crisis team informational debriefing.

☐ **Offer Grief Counseling.** This may be a student's first experience with death. Grief counseling is extremely important. Students should be given every opportunity to express their grief within safe, comfortable settings such as: individually or in small groups; in classroom discussions with their teacher and a crisis facilitator/grief worker. Be prepared for ventilation of strong feelings. All expressions of grief need to be validated. No large group assemblies. Provide resource list for referrals to community agencies and other services. Be aware of the possibility of other students feeling suicidal and be ready to refer them for services.

☐ **Staff members need support and grief counseling.** Crisis workers and grief support professionals can be very helpful to and supportive of staff.

☐ **Emphasize that no ONE Person or Event is to Blame.** Suicide is the most complicated of human behavior. It cannot be simplified by blaming individuals, alcohol, drugs, music, the school, etc. Acknowledge how difficult it is to understand, but do not blame.

☐ **Consider Memorials Very Carefully.** One of the more delicate issues a school faces after a suicide is to decide on appropriate commemorative activities. All efforts must be made to avoid glamorizing or sensationalizing a suicide. Things such as dedicating athletic events or establishing permanent memorials have the potential of providing an invitation to other vulnerable youth to consider suicide. Grieving students may be very insistent that the memory of their deceased friend be honored. These energies are best channeled into constructive projects that help the living. Please see the SIEC Bulletin in the Additonal Material Section for things to consider. Schools need to provide guidelines for appropriate commemorative activities designed to honor and respect any student who dies for any reason, in a fair and equitable way. Design a memorial action plan that treats all deaths in the same fashion. Keep in mind that one or more school community deaths may be a suicide.

Long-Term Effects and Follow-Up

The aftermath of a suicide can be among the most stressful and painful times a school will ever experience. The intense phase of the crisis may last only a few days or weeks, but some effects are ongoing for a year or more. Schools must be sensitive to how special events and the anniversary of the suicide may reawaken distress. Postvention efforts may need to be reintroduced during these times.

Remember, prevention efforts are important but do not substitute for postvention work. It is not appropriate to introduce new prevention initiatives until well after the crisis. Consider formalized six-month and one-year follow-up meetings with staff.

The period of time immediately following a crisis in not the time for prevention education. It is very important to help youth and adults to get through the crisis and process their feelings of grief.

Managing a suicidal crisis may leave a school a stronger, more resilient, and more caring system. Everyone can learn and grow from such an experience.

Source: Adapted from Solanto, Joseph. "The Days After: A School's Response in the Aftermath of Sudden Adolescent Death" in *Teenage Suicide: Prevention, Intervention, Response*. Cosad and Four Winds Hospital, c1984, pg. 10-12; and Carpussi, David. *Adolescent Suicide, Awareness-Prevention-Crisis Response*, Portland State University, Oregon, 1994; and the Los Angeles Unified School District's "Quick Reference Guide for School Crisis management," 1999.

"Suicide Survivors" and Suicide Bereavement

"Suicide Survivor" is a term used to describe someone who actually attempts and then survives a suicide attempt. The same term is also commonly used to describe family members and close friends of someone who has died by suicide. While the language may be confusing, in the section that follows outlining bereavement issues, the term survivor is used to describe individuals close to the person who died by suicide.

Personal stories, clinical reports, and public perception support the belief that grieving the loss of a loved one to suicide is one of the most burdensome forms of bereavement. During the 1990s research was done on grief as a result of suicide. Given the present state of knowledge about suicide bereavement, there is no definitive answer as to exactly how different and difficult suicide bereavement is compared to that following other kinds of sudden, unnatural, untimely traumatic death. It is clear that there are unique qualities to a suicide bereavement. It is important for survivors and their support system to be aware of the complicated mix of social and psychological factors that survivors face.

Survivors struggle to make meaning of the loss. Because suicide is self-inflicted, survivors struggle to make sense of the motives and the frame of mind of the deceased. They struggle to make some sense out of the death. They ask "why" over and over and over again until they finally understand that they will probably never know the answer. Survivors struggle with the loss of the physical presence of their loved one and how to transition into ways to remember this person. They search for something positive and reasonable to come out of the tragedy they have experienced. Over time, the survivor realizes that there was more to their loved one's life than his or her final decision...to die by suicide.

It is critical for the survivor to be able to tell their story, to talk about what has happened until it becomes real and until they come to some resignation, acceptance, and peace of mind. It takes time for survivors to understand that they will never be the same, but they can go on to have meaning and purpose in life. Healing is a long, slow process. In summary, survivors face many unique tasks in their recovery. They spend much more time and energy trying to comprehend the complicated aftermath of the suicide than do other kinds of mourners. When-

ever possible, suicide survivors should be offered the opportunity to interact with other suicide survivors. Their grieving process may take three to five times longer than the average period of grief. It is important for caring family members and friends to be supportive and patient.

Survivors suffer from feelings of guilt, blame, shame, responsibility, and in some cases, relief. They wonder why they didn't see it coming and what they might have done to prevent it. Frequently they blame themselves, are blamed by others, or wish to place the blame on others for the death. In some cases the survivors have suffered from the ordeal of living for a long time with an emotionally disturbed, self-destructive person. They may feel a complicated mixture of loss and relief. There is considerable evidence that the general stigma associated with suicide in our society spills over to the bereaved family members. Caring individuals who genuinely wish to be helpful may feel uncomfortable about how to go about it. The survivor may misinterpret that awkwardness as rejection. It is also possible that the survivor reflects the negative attitude toward suicide in our culture. They may assume or fear that others are judging them negatively and withdraw from the genuine support that is offered. When grieving after any kind of death, it is important to have the opportunity to express one's wide range of emotions, no matter how conflicted. In summary, research shows that interpersonal interaction and social support after a death by suicide is almost always different and more problematic than most other kinds of deaths. Because there is an elevated risk of suicidality associated with loosing a loved one to suicide, survivors need support for their grief and proactive monitoring of their own risk of suicide.

Survivors experience feelings of rejection and/or abandonment, and possibly anger toward the deceased. "How could they do this to me?" "...to us?" It is quite possible that nothing will ever make this death acceptable...or understandable. There is very little research on how different kinds of death effect family functioning. However, there is clinical evidence that suicide is particularly difficult for families no matter what their level of function is, especially if it was the suicide of a child or adolescent. The suicide has the potential to warp patterns of communication and contribute to the development of serious problems in surviving family members. Increased distance between family members is reported far more often than closeness. Other issues include information/communication distortion (hiding the truth about the circumstances of the death), guilt, and identification with the deceased. The fact that one member of the family modeled suicide as a way to solve problems has a powerful influence, particularly on other children. Bereavement following suicide is a very complicated process.

Feelings are Overwhelming

- **Shock:** Sudden, untimely, unexpected, unnatural loss.
- **Stigma:** Investigations by police and reporters can heighten stigma.
- **Shame:** What do I tell people? Do I have to tell them at all?
- **Blame:** School, spouse, parent, employer, therapist (suicide malpractice is the number-one claim brought against psychiatrists, psychologists, social workers, and nurses).
- **Disbelief:** How could things have been "that bad?"
- **Guilt:** How did I contribute to this? Could I have prevented it?
- **Puzzlement/Rejection/Desertion:** How could he do this to me? To our family? I just don't understand, etc.
- **Fear:** What about me? What about other family members? Will we do the same thing? Is this behavior inherited?
- **Anger:** What a stupid thing to do! Why didn't he talk to me? He didn't have to do this.

What Survivors Find Helpful and Healing

- Acknowledgement of the loss...and that it was a suicide
- Information about suicide and the grief process
- Sharing of memories using the name of the deceased
- Support groups especially designed for suicide survivors
- Individual (and family) work with a mental health professional
- Psychoeducational presentations, reading materials, group discussions
- Discussion of specific coping skills and interpersonal tactics for dealing with stigma and shame, anniversaries and other special events
- Help in establishing formal rituals to honor the deceased person's life
- Identification of personal strengths and positive coping skills from other difficult times
- Reading, writing, and expressing grief in a comfortable time, place, and manner
- Patience from loved ones for the time it takes to heal after suicide
- Thoughtful, sometimes unexpected, offers of support from others
- Sensitivity to difficult times: holidays, birthdays, anniversary dates

What Hinders the Healing of Survivors?

- Hiding or denying that the cause of death was suicide
- Blaming themselves or others for the suicide
- Internal or external pressure to "finish" or "stop" grieving and "get on with their life"
- Self-destructive behaviors, e.g., dependency on drugs/alcohol, isolation, refusal of help for depression
- Thoughtless judgmental comments from others
- Lack of supportive, good listeners

A Combination of Individual and Family Psychotherapy and Group Care is Most Helpful (just a few reasons listed below).

- Time limited, individual therapy is often very helpful in sorting through the above list of feelings, events prior to death, questions about the mental health of the deceased.
- Group support comes because members identify with other survivors and allow strong emotions and feelings to be expressed.
- The grieving person sees others who got through this experience and feels understood. Close bonding occurs through shared experiences.
- Ideas are shared on how to deal with everything from legal issues, telling others, to dealing with holidays and anniversaries.
- Group therapist or facilitator recognizes disturbed reactions, depressions, etc.

Common Student Reactions (and Recommended Responses) to Suicide

Everyone grieves differently. Personal and family experiences with death, religious beliefs, community exposure and cultural traditions all play a role. Below are some of the more or less predictable adolescent reactions to a suicide and suggested responses.

- **Shock and Denial.** At first there may be remarkably little response. The reality of the death has yet to be absorbed. *"You are kidding, right?" "This is just a joke-it can't be true."* ***Suggested Response*:** Acknowledge the shock, anticipate the reaction to come, demonstrate a willingness to talk when students are ready.

- **Anger and Protection.** Generally speaking, "black and white" thinking kicks in. Students want someone to blame for this and may openly express/direct anger at the deceased's parents/teachers/boy/girlfriend. *"Why did you let this happen?"*
  ***Suggested Response*:** Listen and then listen some more. Gently explain that it is natural to want to find a reason for things we don't understand. Suggest that suicide is a very complicated human behavior and that there are always multiple reasons…and that blaming another individual may put that person at risk of suicide also.

- **Guilt.** Students close to the deceased may blame themselves. *"If only I had called him back last night;" "I should have known…I should not have teased him…."*
  ***Suggested Response*:** Remind students that only the person who kills him/herself is responsible for having made that decision.

- **Anger at the Deceased.** This is surprisingly common, among both those who were and were not close to the deceased. *"How could she do something so stupid?"*
  ***Suggested Response*:** Allowing and acknowledging some expression of grief is helpful. Explain that this is a normal stage of grieving. Acknowledgment of anger often lessens its intensity.

- **Anxiety.** Students sometimes start to worry about themselves and/or other friends. *"If she could get upset enough to kill herself, maybe the same thing will happen to me (or one of my friends)."*
  ***Suggested Response*:** Help students differentiate between themselves and the dead person. Remind them that help is always available. List resources. Practice problem solving.

- **Loneliness.** Those closest to the deceased may find it almost impossible to return to a normal routine, and may even resent those who appear to be having fun. They may feel empty, lost, totally disconnected. They may become obsessed with keeping the memory of their friend alive.
  ***Suggested Response*:** Encourage students to help each other move forward in positive ways. Notice anyone who seems to be isolating from others and reach out to them, offering resources to help with the grieving process.

- **Hope and Relief.** Once the reality of the death has been accepted, and the acute pain of the loss subsides, students find that life resumes a large degree of normalcy and they come to understand that over time, they feel much better. They can remember their friend without the extreme pain.
  ***Suggested Response*:** Simply remain open to listening to student's feelings, especially on anniversaries (two weeks, months, years etc.), transition times

(graduations etc.). Recognize the importance of both mourning and remembering.

How to Support Grieving Youth

Avoid:

- Giving a lot of advice
- Arguing over trivial matters
- Making moralistic statements about the behavior of the person who died
- Minimizing the loss
- Discouraging or time-limiting the grieving process
- Assigning new responsibilities right away.

Do:

- Learn about the grief process
- Be absolutely genuine and truthful
- Demonstrate love and respect by being attentive
- Encourage talking about feelings and about the deceased friend
- Listen, no matter what!
- Offer to attend the visitation or funeral with a youth
- Allow crying--perhaps lots of crying
- Expect laughter--a sign of happy memories
- Follow the lead of the "survivor" with patience and kindness
- Offer opportunities for remembering; i.e., special events, anniversaries, birthdays
- Expect that your presence may be important, while talking may be limited ("Silence is Golden")
- Share some of your experience with loss, but keep the focus on the person you are supporting
- Help to identify others to talk to (i.e., minister, priest, rabbi or counselor)
- Understand that memorials can be very comforting (i.e., writing a poem, a song, a letter, recording a tape, making a scrapbook, buying a bouquet; writing a letter)
- Believe in healing and growth

Grief Support Centers

Home Health and Hospice of St. Joseph
St. Joseph Healthcare Park
900 Broadway
Bangor, ME 04401
207-262-1810
Fax: 207-262-1928
Contact: Reita Abbott

Pathfinders-Hospice of Eastern Maine
885 Union Street, Suite 220
EM Healthcare Mall
Bangor, ME 04401
207-973-8269 or 1-800-350-8269
Fax: 207-973-6557
Contact: Linda Boyle, Bereavement Coordinator
Vicki Trundy, Pathfinders Consultant

Hospice Volunteers of Waldo County
P.O. Box 772
Belfast, ME 04915
207-930-2677
Contact: Connie Woitowitz
Dr. Peggy Zwerling, Bereavement Coordinator

Hospice Volunteers in Midcoast Maine
45 Baribeau Drive
Brunswick, ME 04011
207-729-3602 or 1-888-486-0340
Fax: 207-729-2721
Contact: Marie Badger

Down East Hospice
c/o Calais Regional Hospital
22 Hospital Lane
Calais, ME 04619
207-454-7521, ext. 126
Fax: 207-454-3616
Contact: Barbara Barnett, Director

Hospice of Aroostook
P.O. Box 688, 14 Carroll Street
Caribou, ME 04736
207-498-2578 or 1-800-439-1685
Fax: 207-493-3111
Contact: Robin Holmes

Pine Tree Hospice
895 W. Main Street
Dover-Foxcroft, ME 04426
207-564-4346
Greenville Satellite Office: 207-695-5283
Contact: Lynne Olson

Hospice of Hancock County
14 McKenzie Avenue
Ellsworth, ME 04605
207-667-2531
Fax: 207-667-9406
Contact: Mary-Carol Griffin, Bereavement Coordinator

Hospice Volunteers of Kennebec Valley
150 Dresden Avenue
Gardiner, ME 04345
207-626-1779
Fax: 207-582-6819
Contact: Barbara Bell

The Children & Teens Program
Hospice Volunteers of Kennebec Valley
ME General Medical Center
150 Dresden Avenue
Gardiner, ME 04345
207-626-1779
Fax: 207-582-6819
Contact: Tina DeRaps, Bereavement Coordinator

New Hope Hospice, Inc.
P.O. Box 757
Holden, ME 04429
207-843-7521
Fax: 207-843-6645
Contact: Patricia Eye
Nancy Burgess

Program for Grieving Children and Teens
Androscoggin Home Care and Hospice
15 Strawberry Avenue
Lewiston, ME 04240
207-777-7740 or 1-800-482-7412
Fax: 207-777-7748
Contact: Mary Heath (ext. 1341)
Sally Brochu (207-777-8520 - St. Mary's)

HomeHealth Visiting Nurses of Southern Maine
901 Washington Avenue, Suite 104
Portland, ME 04103
207-775-7231 or 1-800-660-4867
Fax: 207-775-5520
Contact: Wendy Hammond

Maine Medical Center
Department of Patient & Family Services
22 Bramhall Street
Portland, ME 04102
207-871-4226
Contact: Connie Korda
Meet 2nd and 4th Monday @ 7 pm

The Center for Grieving Children
P.O. Box 1438
Portland, ME 04104
207-775-5216
Fax: 207-773-7417
Contact: Ann Lynch, Executive Director
Linda Kelly, Program Director,
Patricia Ellen, Outreach Director

Kno-Wal-Lin Home Care and Hospice
170 Pleasant Street
Rockland, ME 04841
207-594-9561 or 1-800-540-9561
Fax: 207-594-1461
Contact: Sarah Dwelley
Frank Magrogan

HomeHealth-Visiting Nurses of Southern Maine
Seacoast Hospice-Bridges
15 Industrial Park Road
10 Hampton Road
Saco, ME 04072
207-284-4566 or 1-800-660-4867
Fax: 207-282-4148
Contact: Susan Detullio

Hospice Volunteers of Somerset County
P.O. Box 3069
Skowhegan, ME 04976
207-696-5870
Contact: Linda Burkhart, Director
Andrea Smith, Volunteer Coordinator

VNA Home Health Care
50 Foden Road
South Portland, ME 04106
207-780-8624 or 1-800-757-3326
Fax: 207-756-8676 or 207-756-8677
Contact: Colleen Hilton

Camp Ray of Hope, Hospice Volunteers of Waterville Area
304 Main Street, P.O. Box 200
Waterville, ME 04901
207-873-3615
Contact: Dale Marie Clark (dmclark@hvwa.org)
web site: www.hvwa.org

Hospice Volunteers of the Waterville Area
304 Main Street, P.O. Box 200
Waterville, ME 04901
207-873-3615
Contact: Dale Marie Clark, Executive Director

Family Therapy Associates
Cottage Place, 433 US Rt. 1, Suite 110
York, ME 03909
207-363-4000
Fax: 207-363-1034
Contact: Bobbi Gray

Pete's Place, A Center for Grieving Children & Families
Wentworth Douglas Hospital
1 Webb Place
Dover, NH 03820
603-740-2689
Fax: 603-742-7210
Contact: Jan Arsenault, Program Manager

Seacoast Hospice-Bridges
10 Hampton Road
Exeter, NH 03833
603-778-7391
Fax: 603-418-0040
Contact: Meg Kerr, Bridges Coordinator
Donna Theobold, Bereavement Coordinator

Generally speaking, if you call your local hospice, they will help you identify grief support resources.

Taking Care of Ourselves

Dealing with a suicidal youth is one of the more difficult challenges with which we may be faced in our lives. In addition to our responsibilities to young people, we also have responsibilities to ourselves and to other professionals, parents, and community members.

Here are some tips for self-care:

Acknowledge Your Own Feelings and History

A suicidal crisis will always bring out intense feelings in caregivers. Sometimes feelings from the caregiver's own past experience are displaced onto the suicidal individual. The caregiver may feel angry or may resent the individual because he or she reminds the caregiver of personal unresolved conflicts. If you have these intense feelings, acknowledging their existence may help you understand the root causes. It may be helpful to talk to your peers or other staff members. If you don't think you can deal with an individual effectively without interference from these feelings, you should try to get another person to handle the suicidal individual. In any case, it is important to know your own limits and capabilities. No one is expected to be perfect.

Sometimes dealing with a suicidal individual can arouse suicidal feelings in the caregiver. It is essential that you gain a clear and comfortable understanding of your own feelings and seek professional counseling, if necessary.

Avoid Over-Involvement

Teamwork works! You must be able to resist the desire to be omnipotent. An intensely dependent individual can attribute tremendous power to you as a potential rescuer. But this power gives you too much responsibility for another's life. Emotional over-involvement of caregivers in an emergency is unhelpful and at times destructive. Sometimes there is a fine line between being involved and over-involved. When we are over-involved we don't always know it. It is the responsibility of other staff members to confront the person who they sense has become over-involved. One person alone cannot provide all of the necessary support a suicidal individual will need.

Debrief the Incident With the Whole Staff

A suicidal incident is such an emotionally charged situation that it will always leave you with leftover feelings. Taking time to debrief is critically important for all involved. Go over the incident in detail to confirm that you dealt with the situation as best you could and to consider with others what might be done in the future. It is important for your co-workers to support the notion that no one is expected to be perfect. We need each other as resources and for support. Outside resources, such as a mental health crisis worker or a staff member from a survivor's group or grieving center, may also be very helpful. We tend to be very critical of ourselves following a suicide prevention or crisis intervention. It is common for us to question our judgment when we are assessing and intervening in a suicidal situation. The best way to deal with that is to share the responsibilities of decision-making. Involve your pre-designated school crisis team members and community-based helping professionals, if available.

Understand the Role of Responsibility in Suicides

Although involvement in a life-saving situation carries a lot of responsibility, you cannot be fully responsible for another individual's life. You must try to prevent a suicide, but the ultimate decision rests with the individual.

Think of the Special Ways to Take Care of Yourself

It is often extremely important to set up a routine, almost ritualized but familiar ways to "unwind" after a suicidal intervention. Consider what you like to do to take care of yourself after a semi-difficult day, and find comfort in that routine after an especially intense suicide intervention. Connect with something you love (e.g., walking your dog, taking a peaceful bath, having a nice dinner with your partner, going to a light-hearted movie). And definitely make contact with someone that evening after a stressful day. Avoid being alone with your feelings about the interaction that is filling your thoughts.

APPENDICES

STATEWIDE HOTLINE – 1-888-568-1112

CRISIS INTERVENTION SERVICES

Licensed by Department of Health and Human Services (DHHS)

	Walk-in Crisis and Triage Services/Mobile Outreach Services
Region 1	**Cumberland County Crisis Service**
Cumberland County	Ingraham, Inc. Department of Health and Human Services (DHHS) Maine Medical Center Sweetser Children's Services
	York County Crisis Services
York County	Counseling Services, Inc. Department of Health and Human Services (DHHS) Southern Maine Medical Center
Region 2	**Ken-Som Crisis Services**
Kennebec and Somerset Counties	Kennebec Valley Mental Health Center Crisis & Counseling Center Maine General Medical Center
	Coastal Crisis Response Services
Sagadahoc, Lincoln, Knox, & Waldo Counties, plus Brunswick/Freeport Area	Sweetser Children Services Mid-Coast Mental Health Center
	Western Maine Crisis Services
Androscoggin, Oxford, & Franklin Counties	Tri-County Mental Health Services Evergreen Behavioral Health Services Oxford County Crisis Response Rumford Group Homes
Region 3	**Aroostook Crisis Response**
Aroostook County	Aroostook Mental Health Center
	Northeast Crisis Response
Penobscot, Piscataquis, Hancock, & Washington Counties	Community Health & Counseling Services Washington County Psychotherapy Associates

SUICIDE PREVENTION SUPPORT SYSTEM

Statewide Crisis Hotline -- 1-888-568-1112

Statewide Emergency Numbers:

1. 911
2. Poison Control Center -- 1-800-442-6305--TTY--1-800-222-1222
3. Maine State Police -- 1-800-432-7381-- TTY--1-888-524-7900
4. Child Abuse & Neglect -- 1-800-452-1999--TTY--1-800-963-9490
5. National Domestic Violence Hotline--1-800-799-7233--TTY--1-800-787-3224

Local Numbers: _____

Hospital Emergency Room _____

School Contact(s) _____

_____

_____

Referrals (Practitioners/Therapists) _____

_____

Child & Adolescent Specialists _____

Family Systems Therapists _____

_____

Drug & Alcohol Specialists _____

_____

Interpreters (Deaf, Spanish, Hmong, Etc.) _____

_____

_____

For more informational materials call:

Maine Office of Substance Abuse Information and Resource Center
1-800-499-0027(Maine Only) TTY-1-800-215-7604

Maine Youth Suicide Prevention

Education, Resources and Support–It's Up to All of Us.

Reporting on Suicides

Talking about suicide does not cause suicides

Certain forms of reporting these tragic events have been shown to help prevent suicides. Communicating news of suicide deaths and reporting on or recommending suicide intervention and prevention measures is a critical function, which only the media can fulfill. The presentation of facts about a suicide and the language used to convey those facts within news coverage can diminish the atmosphere of rumor and, moreover, the possibility of increased suicidal behavior.

"Fine-tuning" such stories along the parameters outlined below can actually promote the safety of individuals at-risk:

Report in a non-sensationalized, non-romanticized, non-graphic fashion the news of a suicide or series of suicides. Establish a foundation that avoids placing blame on events, friends, and relatives, but acknowledges the grief process for the community.

Provide concise factual information that increases public awareness of risk factors, warning signs, and possible actions to help a suicidal person. In most cases, there are warning signs of an impending suicide. Yet, at the time of a suicide, those closest to the victim did not know about, or may not have seen, those warning signs. Finding and focusing on these warning signs can help to increase general public awareness of how to recognize and respond to help a suicidal person.

Describe what is being done to promote safety in the aftermath of a suicide.
Local crisis intervention activities usually follow a suicide. Publicizing the significant efforts underway by schools and community organizations give options for help to community members affected by the tragedy.

List available community resources for individuals at-risk. Information on available resources, including hotline number(s) and other local resources, can assist individuals at-risk, their friends and family members, learn where to get help with their concerns. ***Maine's Statewide Crisis Hotline, 888-568-1112***, is an appropriate resource in any story related to suicide and can be included as a resource.

Periodically feature stories about people who have made it through difficult situations. Stories that present positive ways of coping with problems aid in the prevention of further suicide attempts. For vulnerable individuals, these stories can provide positive role models and alternative solutions to ending one's life.

What research has shown about the Copycat Effect

Findings from numerous American and international studies during the last thirty years indicate the likelihood of copycat suicides are increased by certain types of reporting. The classic cases are the increase in the national suicide rate by 17% after Marilyn Monroe died by suicide and the international copycat suicides after Kurt Cobain's death.

The increase in suicidal behavior, especially among youth, following prominent news coverage of a suicide comes about because the coverage falls outside certain parameters. Research shows that problems occur even with regard to the use of seemingly harmless phrases like "successful suicides" and "failed attempts." These tend to give the message that to kill oneself is a "success" and to try, but not die is a "failure." Furthermore, publicizing graphic and repetitive representations of suicides (including the method used and how obtained), and glorifying the suicide victim appear to increase the actual numbers of suicide through the "copycat effect," a well-researched form of behavior contagion.

The following reporting practices have been linked to increased suicidal behavior:

Providing sensational coverage of suicide. Graphic news coverage of a suicide can heighten a vulnerable person's preoccupation with suicide. Reports that employ dramatic photographs related to the suicide (e.g., photographs of the funeral, the deceased person's bedroom, and the site of the suicide), and detailed verbal imagery of the suicide scene become exacting models for other at-risk persons. Details about the method of suicide also may encourage imitation of the suicidal behavior among vulnerable persons.

Glorifying or romanticizing suicide or persons who die by suicide. Reports that idealize or romanticize someone who dies by suicide may Exaggerated community expressions of grief (e.g., large public eulogies, flying flags at half-mast, and erecting permanent public memorials) cause inflated reinforcement of the suicide. Such actions may contribute to suicide contagion by suggesting to susceptible persons that society is honoring the suicidal behavior of the deceased person, rather than mourning the person's death.

Focusing only on the suicide victim's positive characteristics. While statements praising the deceased as "a great kid" or "someone with a bright future" are important, acknowledgement that the deceased was experiencing problems or struggles can help to give a more accurate picture of the individual's situation. When the deceased person's problems are not acknowledged, suicidal behavior may be attractive to other at-risk persons, especially those who rarely receive positive reinforcement.

Presenting simple explanations for suicide. Suicide is seldom the result of a single event. Rather, it is the rare act of a troubled person struggling with complex circumstances. During the period immediately after a death by suicide, grieving family members and friends are stunned and may find a loved one's death by suicide unexplainable. They may deny that there were warning signs or may place blame on one person or event. Presentation of suicide as a way of coping with personal problems (e.g., the break-up of a relationship or retaliation against parental discipline) may suggest suicide as a possible coping mechanism to other at-risk persons.

Engaging in repetitive or prominent reporting of suicide. Excessive coverage of a suicide tends to promote and maintain a preoccupation with suicide among at-risk persons, especially young people. Front-page coverage of a suicide and use of the word 'suicide' in a headline has been shown to increase copycat suicidal behaviors.

Sources: *MMWR*, Vol. 43/No. RR-6, "Suicide Contagion and the Reporting of Suicide: Recommendations from a National Workshop," AFSP Media Guidelines, and *The Copycat Effect* (Loren Coleman, Simon and Schuster, 2004).

For resources, information, and data, call the MYSPP Information Resource Center: 1-800-499-0027

Distributed by the Maine Youth Suicide Prevention Program, Coordinator:
207-287-9968 or toll-free 1-800-698-3624.
A program of the Maine Children's Cabinet. Revised 3.04

Selected Resources

Website resources on suicide prevention are an important new tool. The following sites will supply links to a wealth of infromation. All updated as of August 2004.

Suicide Prevention & Related Information Resources

Maine Youth Suicide Prevention Web Site
http://www.maine.gov/suicide
This site is created through a joint effort of the Maine Injury Prevention Program in the Bureau of Health, Department of Health & Human Services and the Office of Substance Abuse. It includes information about prevention efforts in Maine, resources available, Maine and National data, and a new searchable database of all IRC resources.

Maine Office of Substance Abuse Information Resource Center (OSA/ IRC)
http://www.maineosa.org/irc
The OSA/IRC maintains a variety of suicide prevention resources. Print materials, books, and videos may be obtained by calling 1-800-499-0027 (maine only), TTY: 1-800-215-7604 or by e-mail at IRC: osa.ircosa@maine.gov

National Alliance for the Mentally Ill (NAMI) of Maine
http://www.me.nami.org
NAMI of Maine is a membership organization dedicated to improving the quality of life for people living with mental illness. They provide information and referral to services for mental illness, local support groups, education and systems advocacy. 1-800-464-5767 (tty same)

American Association of Suicidology (AAS)
http://www.suicidology.org/ Phone: (202)237-2280, Fax: (202)237-2282
A United States organization of concerned persons and agencies working in suicide prevention. American Association of Suicidology, Central Office, Suite 310, 4201 Connecticut Avenue, N.W., Washington, DC, 20008. AAS promotes research, public awareness programs, and education and training for professionals and volunteers. In addition, it serves as a national clearinghouse for information on suicide. This site provides information you should know about suicide, membership information, a listing of AAS publications, and conference information.

American Foundation for Suicide Prevention (AFSP)
http://www.afsp.org/ Phone: (212)410-1111, Fax: (212)363-6237
The American Foundation For Suicide Prevention is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP, 120 Wall Street, 22nd Floor, New York, NY 10005. This site is very easy to navigate and is updated regularly. It contains some very interesting articles on the subject of suicide and the issues surrounding it.

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/ Phone: (404)639-3311
The CDC is an agency of the U.S. Department of Health and Human Services. In addition to health statistics, this website provides access to publications, health information, and funding announcements. Centers for Disease Prevention and Control, 1600 Clifton Road, NE, Atlanta, GA 30333.

Centre for Suicide Prevention
http://www.suicideinfo.ca (click on SIEC Alert)
The Centre for suicide is a library and resource center. They do not do crisis intervention or counseling; instead, this site gives recommendations on where to get help, in both Canada and the U.S. Located on this site is a comprehensive list of suicide prevention resources, crisis support information, and links to other helpful suicide prevention sites. This site is very user friendly. They regularly publish SIEC Alerts that may be helpful. Each one explores a topic and provides excellent resources on that suicide-related topic.

National Suicide Prevention Resource Center
http://www.sprc.org Phone: (877) GET-SPRC
The Suicide Prevention Resource Center (SPRC) supports suicide prevention with the best of science, skills and practice. The Center provides prevention support, training, and informational materials to strengthen suicide prevention networks* and advance the National Strategy for Suicide Prevention.

Acknowledgments

In producing and updating a manual such as this, several individuals, reference sources, websites, and readily available suicide prevention resources are consulted. In general, many authorities and authors use and recycle commonly repeated information that is freely shared to benefit our goal of saving young people's lives. The following is a list of people and sources that were used as the building blocks for this manual. Any organization or individual that is not credited below was omitted as an oversight, and upon notification, credit will appear in future editions.

Generally speaking, people who work in suicide prevention are very dedicated to this field. The researchers, clinicians, educators, crisis workers, and survivors have been remarkably generous in their willingness to work together to share information in hopes that the tragedy of suicide can be prevented. We, in Maine, are most appreciative of the help we have received to create and maintain the Maine Youth Suicide Prevention Program efforts, including Gatekeeper Training.

Many individuals have assisted us in assembling this training, including John Kalafat, Maureen Underwood, Karen Dunne-Maxim, Diane Ryerson, Frank Campbell, Silvia S. Canetto, Madelyn S. Gould, Steven Stack, Paul Marsden, Cheryl DiCara, Deb Stone, Bill Deane, David Lester, Lanny Berman, Daniel Cohen, Paul Quinnet, Iris Bolton, Mary Drexler, Sue Eastgard, Heather Fiske, David Clark, Sally Brown, Marsha Stultz, Murray Straus, Ira Beckow, Tom Radecki, William Forstchen, Edward J. Rielly, and Karyl Chastain Beal.

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May all our efforts go forth to prevent suicides.

With appreciation,

Susan O'Halloran
Augusta, Maine

Loren Coleman
Portland, Maine
August 30, 2004